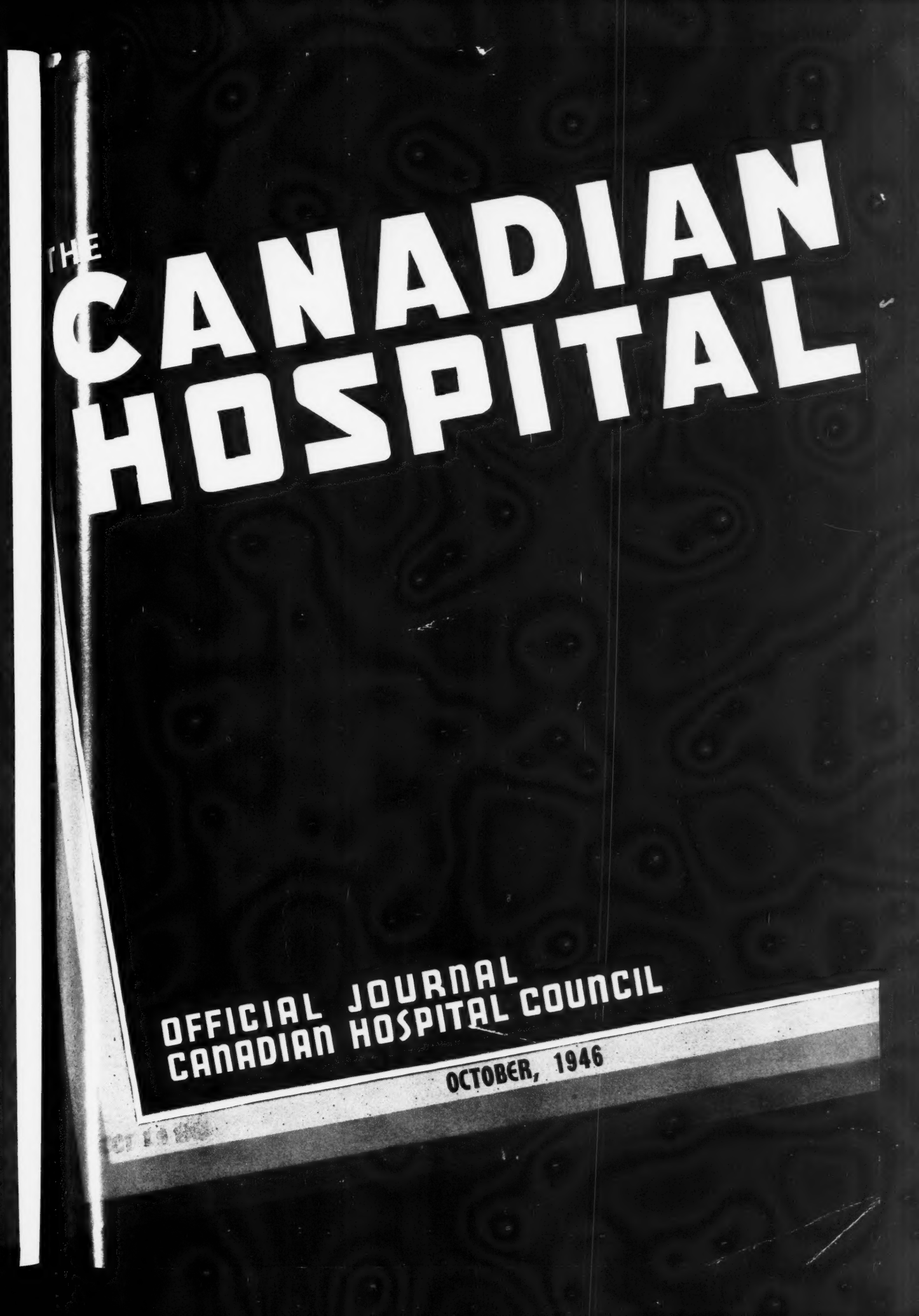

THE
CANADIAN
HOSPITAL
OFFICIAL JOURNAL
CANADIAN HOSPITAL COUNCIL
OCTOBER, 1946

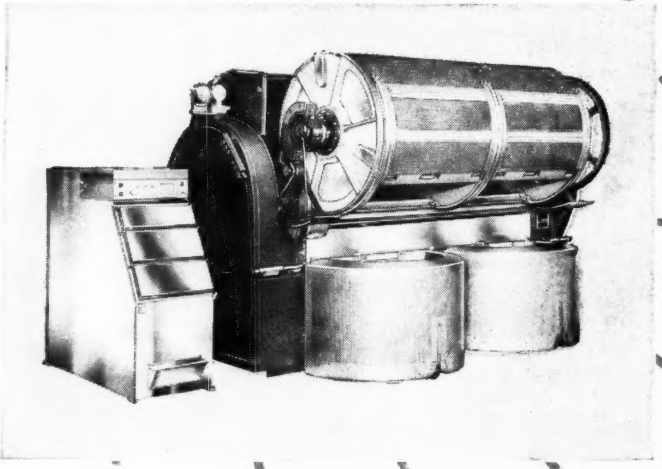
"MODERNIZING" your laundry will Pay for Itself!

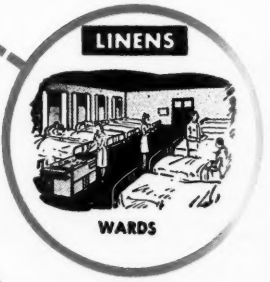
LAUNDRY processing and equipment have advanced during the past few years. New developments make it possible to modernize hospital laundries and pay for the cost quickly, through increased production . . . savings in labor . . . reduced linen replacements . . . and lower power, supply, steam and water costs.

Modernizing the laundry greatly benefits all other hospital departments. It assures a constant supply of fresh, sterile-clean linens on which every department depends for proper functioning. It helps the entire hospital render better service to patients and staff.

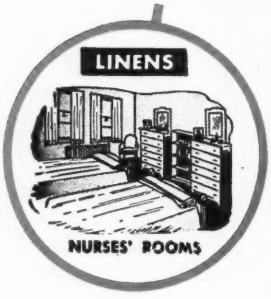
Through our Laundry Advisor you can quickly find out how improved laundry equipment and methods will benefit your hospital. Write us today.

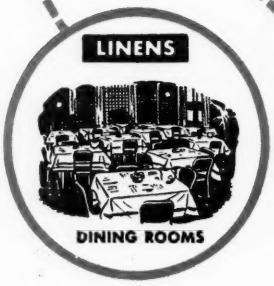
CASCADE Automatic Unloading Washer with Companion Control performs every operation of washing cycle and unloads work automatically. Helps speed linens to all departments on shorter schedule.

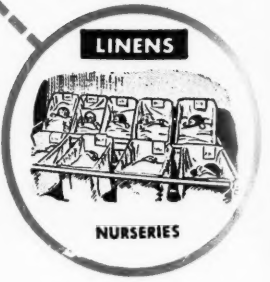




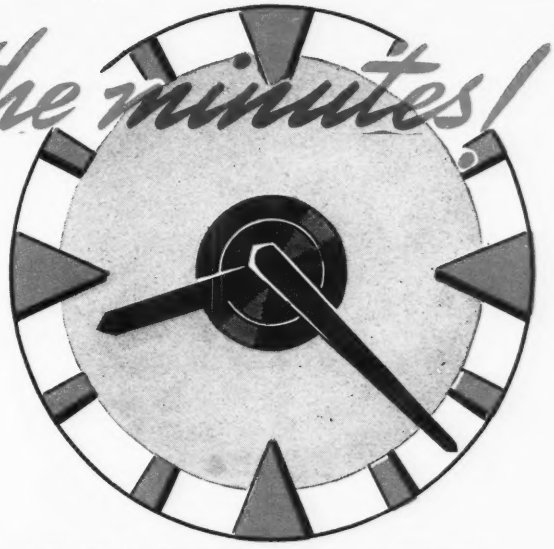
The CANADIAN LAUNDRY MACHINERY CO. LIMITED
47-93 STERLING ROAD, TORONTO 3, ONT.







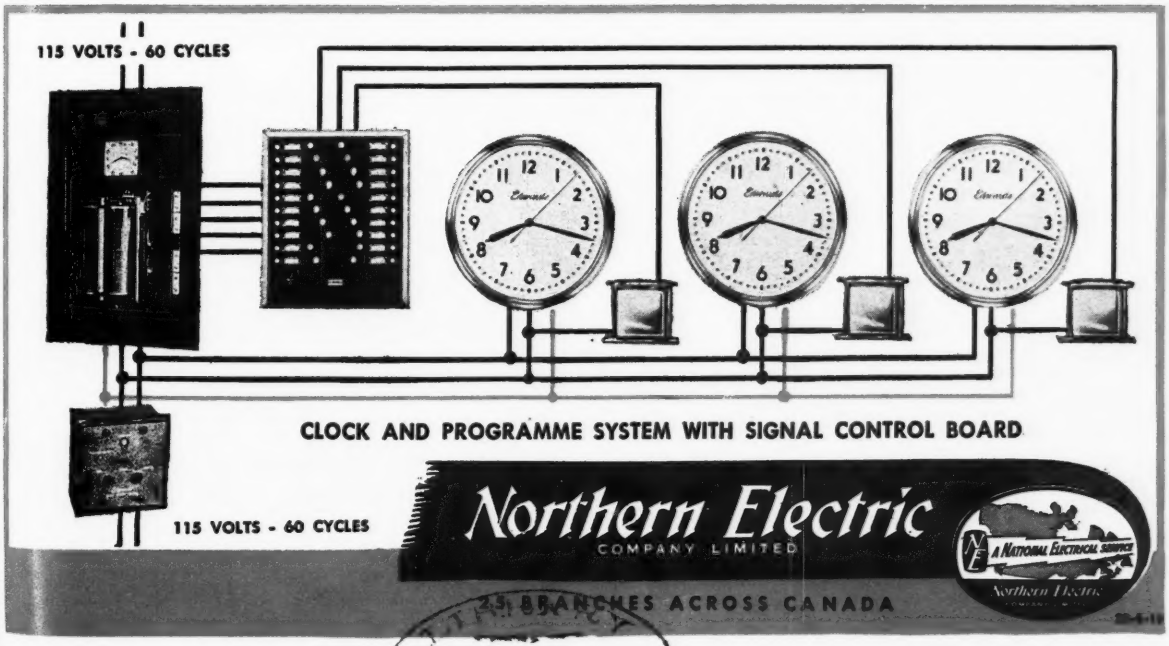
Ticking off the minutes!



CENTRALLY-CONTROLLED CLOCK AND PROGRAMME SYSTEMS

EDWARDS Systems are adaptable to a very wide variety of uses in schools, colleges, institutions, public buildings and industry.

Consult Northern Electric with your particular problem. Write today for literature.



CLOCK AND PROGRAMME SYSTEM WITH SIGNAL CONTROL BOARD

Northern Electric
COMPANY LIMITED

A NATIONAL ELECTRICAL SERVICE

25 BRANCHES ACROSS CANADA

MEDICAL FACULTY. McGILL. OCT 10 1946

There's Always a Favorite!

To dietitians

GIBBONS QUICKSET JELLY DESSERTS

is "Tops".

Rich in flavor—ready to serve in twenty minutes, in six delightful flavors:

Lemon, Orange, Wild Cherry, Strawberry, Lime, Raspberry.

Simply add water—NO SUGAR REQUIRED.

"A Cent a Serving"

Another favorite is that smooth creamy textured Chocolate and the rich, satisfying, BUTTERSCOTCH Pudding Desserts.

Simply add milk—NO SUGAR REQUIRED.

Delegates are cordially invited to visit our display of attractive desserts—Booth 40, Ontario Hospital Association Convention—or mail orders to

GIBBONS
QUICKSET DESSERTS
TORONTO CANADA

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Contents

Vol. 23 **OCTOBER, 1946** No. 10

More than a Surgical Strand...
IT'S A D&G EYE SUTURE

As surgical research becomes more specialized, Davis & Geck provides sutures to meet the specific requirements of new and improved surgical techniques. Through close collaboration with eminent authorities in ophthalmologic surgery, a complete selection of double and single armed sutures for various types of eye surgery have been developed at D&G. Made of Anacap black silk, plain and chromic catgut, D&G Eye Sutures are equipped with Atraumatic needles especially designed for use in corneal transplant and in muscle, cataract, and eyelid surgery as well as suturing of the canthal ligament, and are particularly adaptable to many of the classic techniques. The booklet "D&G Eye Sutures", recently revised and brought up to date, is available on request.

D&G Sutures

"This One Thing We Do"

D & G sutures are obtainable through responsible dealers everywhere

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McGILL

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The Federation of Hospital Associations in Canada in co-operation with the Federal and Provincial Governments and the Canadian Medical Association

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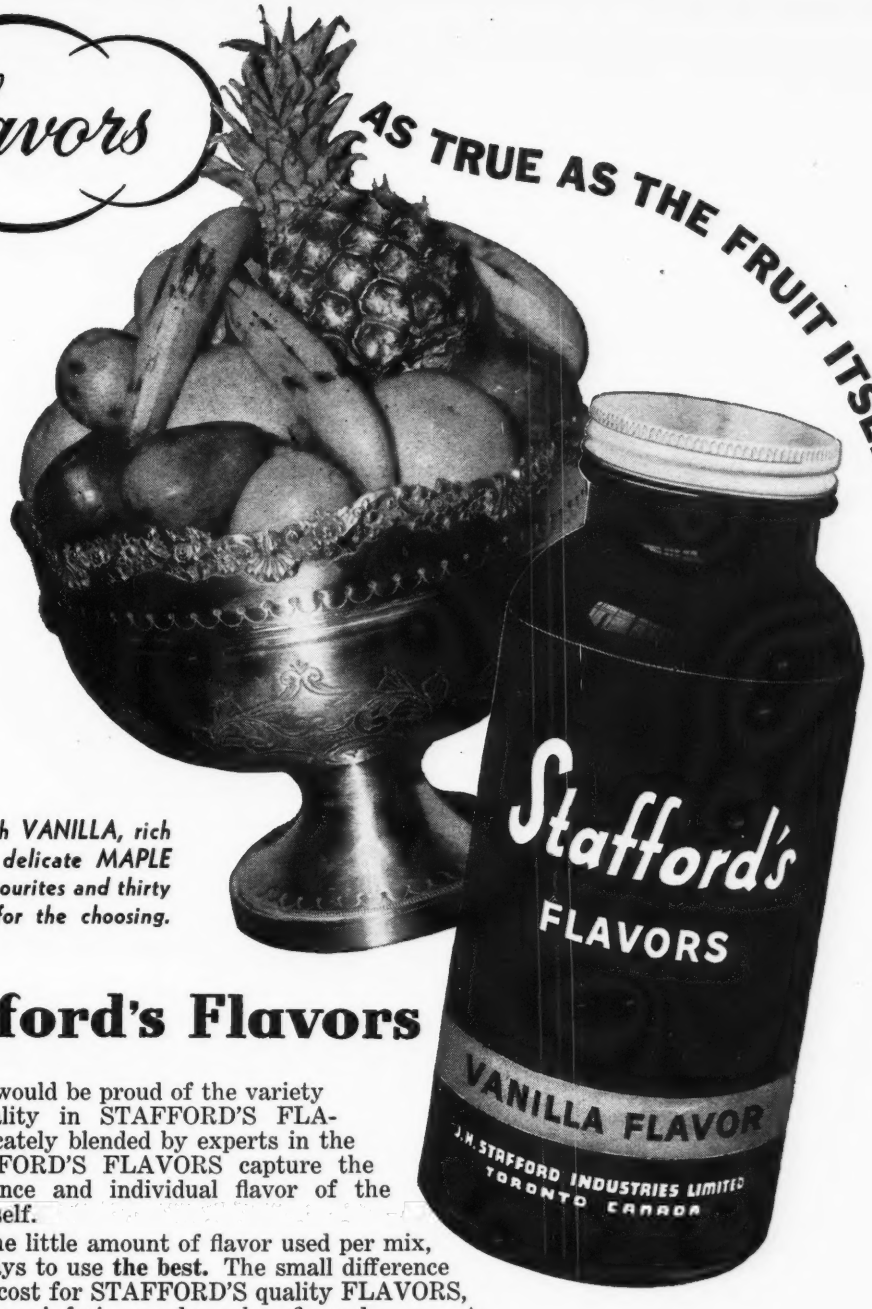
Flavors

AS TRUE AS THE FRUIT ITSELF



full bodied, smooth VANILLA, rich STRAWBERRY, a delicate MAPLE . . . these three favourites and thirty others, are yours for the choosing.

Stafford's Flavors

Mother nature would be proud of the variety and true quality in STAFFORD'S FLAVORS! Delicately blended by experts in the art, STAFFORD'S FLAVORS capture the true essence and individual flavor of the fruit itself.

For the little amount of flavor used per mix, it pays to use **the best.** The small difference in cost for STAFFORD'S quality FLAVORS, over inferior grades, when figured on a cost-per-mix basis, is hardly noticed . . . but what a vast difference it makes in the finished product.

In buying flavors you have to put fullest confidence in the manufacturer . . . that's why STAFFORD'S FLAVORS find favour everywhere.

Stafford's LABORATORY CONTROLLED BASIC FOOD MATERIALS

COAST-TO-COAST DISTRIBUTION

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HOSPITAL FURNISHINGS

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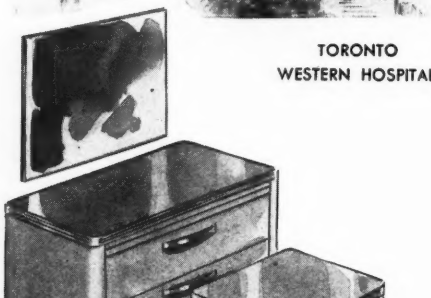
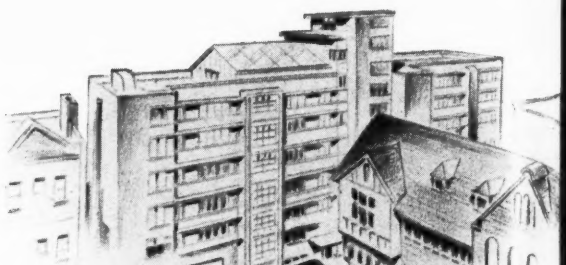
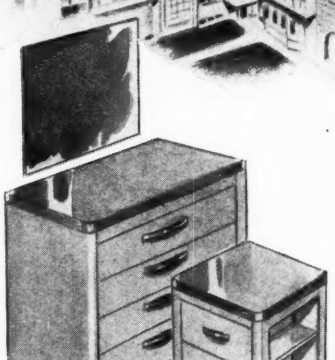
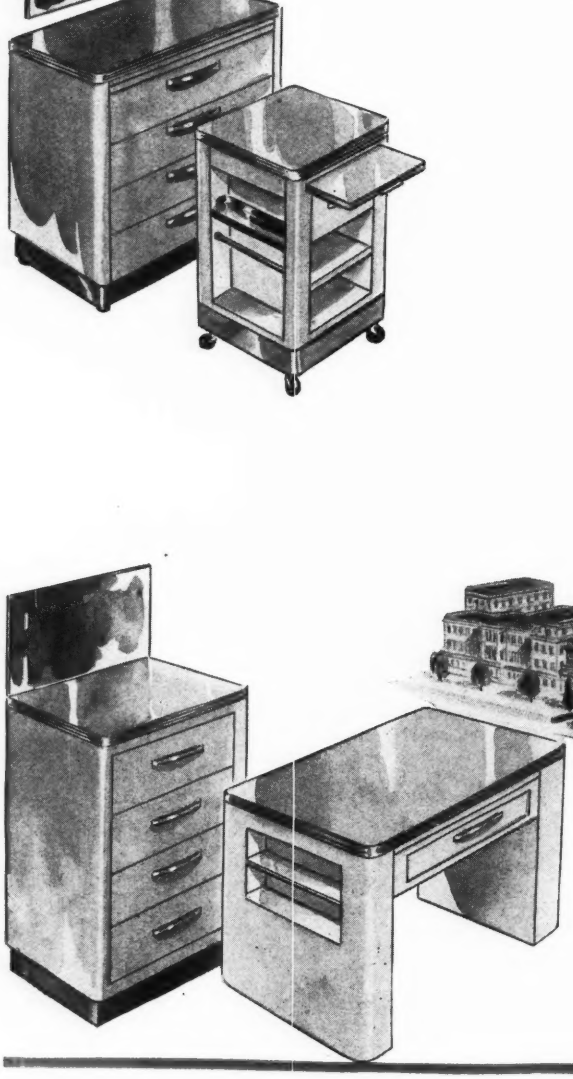
WESTERN HOSPITAL

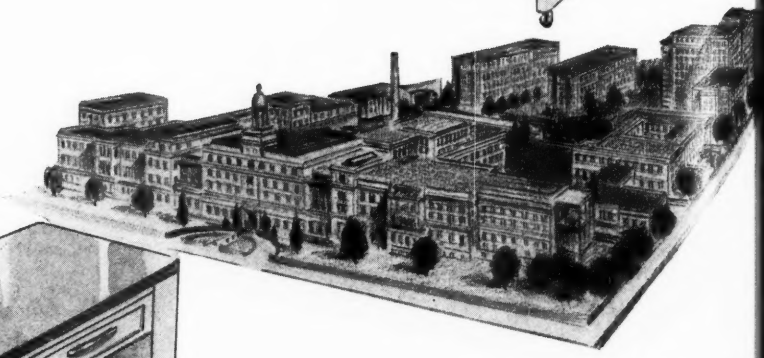




QUEEN ELIZABE
HOSPITAL







TORONTO GENER
HOSPITAL

HAT LEAD IN COMFORT . . .

UTILITY . . . IN EFFICIENCY!

From years of experience, Eaton's Contract Sales Department is wise in the ways of improving efficiency. In many hospitals throughout Canada, as in these, our skilled designers have thoughtfully produced complete furniture and fittings, finished in custom-made colour schemes, to blend with advanced architectural settings.

The up-to-date hospital furnishings featured here have space saving neatness . . . durability and utility . . . as well as eye appealing style. Each piece has been especially constructed to provide the staff and patient with convenience and comfort . . . hard wearing surfaces . . . plastic stain resisting tops . . . stainless steel recessed bases . . . free wheeling ball bearing casters . . . noiseless roller operating drawers . . . unique mirror attachment to dresser . . . smoothly rounded corners for safety and cleanliness.

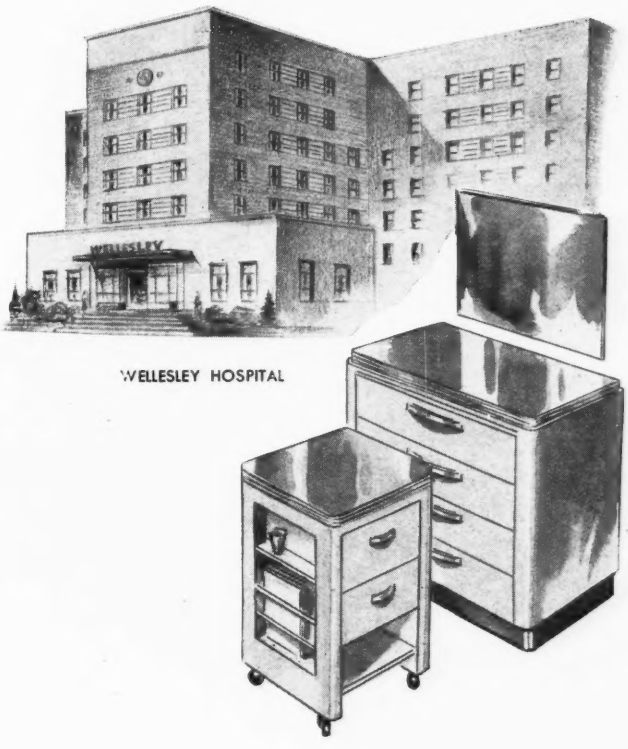
Eaton's recently designed "Perfected" bed screening is proving to be a blessing to nurses and gives a thrill of private relaxation to patients. It has been selected for the new Sunnybrook Hospital.

Detailed estimates will be submitted on complete furnishing schemes for new or remodelled buildings.

Metal furniture illustrated has been fabricated exclusively for the T. Eaton Company by Dominion Metalware Industries Limited.

THE T. EATON Co LIMITED
CANADA

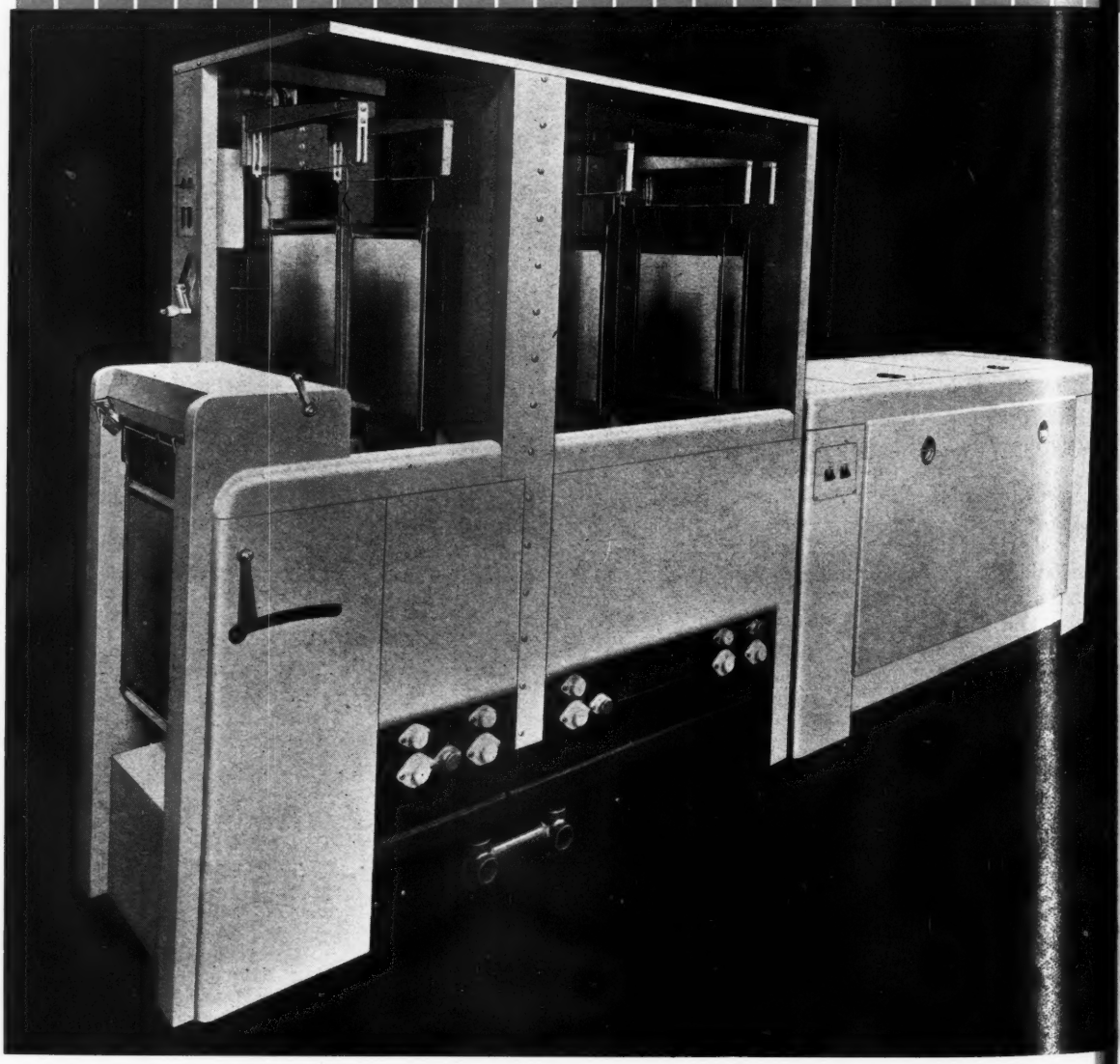
SUNNYBROOK HOSPITAL



WELLESLEY HOSPITAL

IT'S THE NEW MODEL 30

PAKO X-RAY FILMACHINE



Specially designed for Medical X-Ray Laboratories to make film-processing automatically correct

To every specialized and hospital x-ray laboratory that is producing a large number of radiographs per day, the development of the Model 30 Pako X-Ray Filmachine is of momentous importance, because it is destined to supersede present film-processing methods. Here is why:

1. Automatically and completely processes 60 14″ x 17″ films per hour, or any other film of smaller size—through the developer, stop bath, fixer, wash, wetting solution and infray-tube drying tunnel.
2. Automatically controls the time of each processing step, thus eliminating the factor of human error and insuring uniform results.
3. Prevents damage to films — no scratches, no abrasions, no sticking together.
4. Provides variation of developing time in 30-second intervals from 2½ to 5 minutes.
5. Permits viewing of wet emergency film in 3½ minutes after film leaves developing solution.
6. Because processing by this method is reduced to utmost simplicity, it requires less darkroom personnel. This means economy.
7. Saves valuable floor space—overall length only 177″, of which 36″ extends into darkroom; width 36″, height 79″.

There are many more interesting features and advantages which you will want to know about this new Pako Model 30 X-Ray Filmachine—all valid reasons why it will prove a sound investment for busy x-ray departments.

Our appointment as exclusive distributors of the Pako X-Ray Filmachine to the medical field is in recognition of our long and varied experience in planning and installing x-ray equipment, and our Dominion-wide field organization's reputation for competent maintenance and technical service. These experts stand ready to discuss with you the feasibility of a Pako X-Ray Filmachine in your institution.

Write today for full particulars. Address Victor X-Ray Corporation of Canada, Ltd., at nearest branch office.

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DISTRIBUTORS FOR GENERAL ELECTRIC X-RAY CORPORATION

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Aprons . . . Curtains . . . Uniforms stay fresh and clean longer with DRAX!

TRADEMARK REG. CANADA PAT. OFF.

Invisible wax protection makes them resist dirt, soil . . . shed water!

DRAX, an amazing wax rinse, is made by the makers of Johnson's Wax. It gives your washable fabrics an invisible finish that resists dirt, soiling and perspiration . . . sheds water!

Where cleanliness is paramount, and fabrics must be laundered frequently, DRAX protection is truly wise economy. It keeps fabrics clean longer . . . so they need *less* laundering. Then, too, DRAX keeps dirt from getting ground in. It rinses out faster with less agitation . . . and that means longer life for fabrics! DRAX cuts down on replacement costs!

It's easy—it's economical, to use DRAX. You need no extra equipment, no special skills. For only a few cents you can DRAX dozens of garments in a single bath or wheel. Try DRAX in your laundry. See how it actually improves the appearance and "feel" of your fabrics . . . saves on maintenance and laundry costs!

FREE!
A sample of DRAX with complete instructions for use. Just fill out and send this coupon.

DRAX is made by the makers of Johnson's wax
(A name everyone knows)

S. C. JOHNSON & SON, LTD.
Dept. CH-10 Brantford, Canada.
I would like to try laundry type DRAX: Please send me a FREE sample plus literature and instructions.

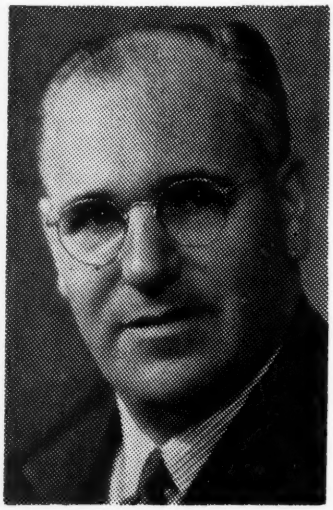
Name _____
Hospital _____
Address _____
City _____ Province _____

Across the Desk

By C. A. E.

K. C. Hossick Heads Narcotic Division

Mr. K. C. Hossick of Ottawa has been named chief of the narcotic division, Department of National Health and Welfare, the acting minister, the Hon. Dr. J. J. McCann, announced recently. This division of the department is responsible for administration of the Opium and Narcotic Drugs Act and for carrying out Canadian commitments in the international regulation of the trade in narcotics.



Mr. Hossick, assistant chief of the division since 1928, succeeds Col. C. H. L. Sharman, who retired earlier this year.

* * * *

Sully Aluminum at Long Branch

Sully Aluminum are now fully established in their new plant and location at Long Branch, Ont., alongside of their parent company, Neptune Meters, Limited. They have completed a new foundry and service building, including a fully-equipped cafeteria serving both plants. The building is all on one floor being 345′ x 70′ with a total floor area of about thirty thousand feet.

Most modern equipment for the production of brass castings is embodied in a complete mechanical sand handling and moulding unit, designed for large production of their primary product, water meters. Extensive finishing and polishing equipment has been installed for the finishing of their complete line of cast aluminum cooking utensils, and kitchen equipment. The two plants have a combined area of ten acres, which leaves plenty of room for future expansion.

* * * *

Gordon Armstrong Appoints Livsey

Mr. Ralph Livsey, for 28 years with the Berger Manufacturing Division of Republic Steel Corporation and for a number of those years Manager of Special Product Sales, has recently been appointed Manager, Air Control Division, The Gordon Armstrong Company, Bulkley building, Cleveland.

The Gordon Armstrong Company's best known products are unit ventilators sold under the name "Silentaire" and baby incubators sold under the name "Armstrong X-4". Thousands of these devices are today in use in the United States and on practically every other continent.

(Continued on page 16)

Safe, fast, sanitary dish-washing with

Monel EQUIPMENT

Equipment fabricated in Monel is the answer to many dish-washing problems, for Monel is strong, tough and rustless, easy to keep clean, is unaffected by cleansing compounds. Monel is solid right through with no coating to chip, crack, peel or wear away, thus years of trouble-free service is assured. For additional information, write for illustrated literature.

CLIP THIS COUPON ▼

THE INTERNATIONAL NICKEL COMPANY OF CANADA, LIMITED

25 King Street West, Toronto, Ont.

Please send me a copy of booklet F-71 entitled "Everywhere on the Continent #35 Monel food service equipment" and booklet entitled "Blakeslee + Built".

Name.....

Address.....

You can *SEE* the quality of a Johnson & Johnson ready-made COTTON BALL

DO THIS - Pull a J & J Cotton Ball apart and see for yourself why these machine-made balls are firm, well-shaped . . . why they stay compact.

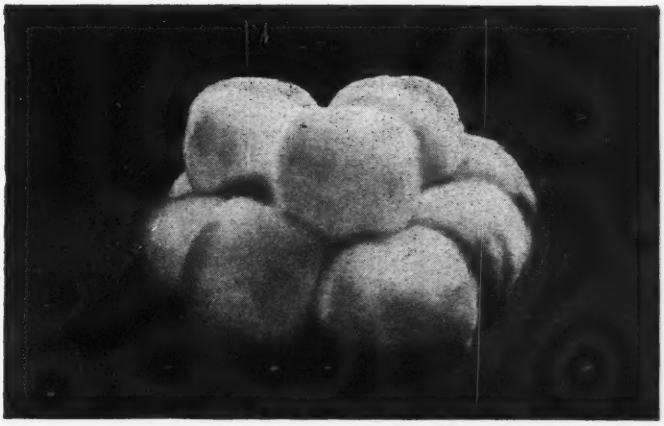
Modern machinery expertly spins the soft, *long-fibred*, surgical-quality cotton into a ball that is uniform in size, shape, weight . . . and is free from nibs. Available in two sizes: *Medium and Large.*

So specify J & J Ready-Made Cotton Balls . . . and avoid the loss of time . . . the cost of labor . . . needed for the old-fashioned, hand-made cotton balls. *An inferior product,* they definitely cost more than machine-made balls . . . *frequently more than the material alone!*

With J & J . . . it's machine-made

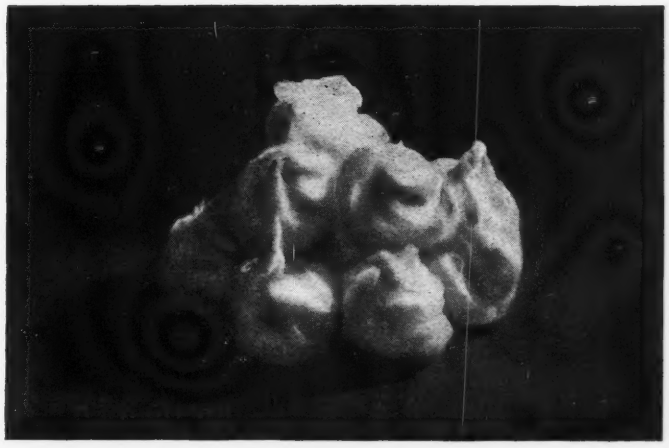
look at *THIS*...

Here's how J & J Cotton Balls come to you — *all ready for use!* In addition to absolute uniformity, these machine-made cotton balls are economical because of efficient mass-production methods. Yes, even excluding labor costs, they usually cost less than hand-made balls.



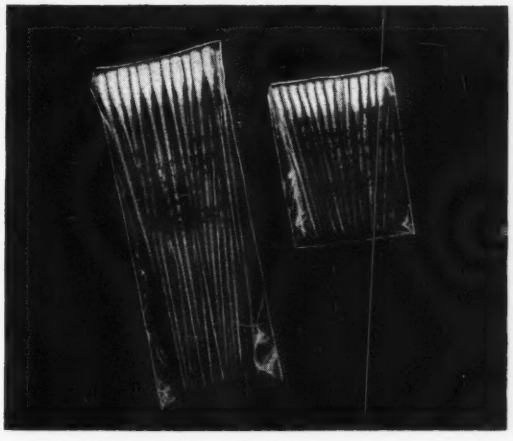
then remember *THIS*...

The inferior, hand-made product. Never uniform . . . with always the tendency to use *more* cotton than necessary. Result: waste and higher costs. Oversized cotton balls also waste solutions in which they are dipped.



AND...don't forget modern J & J COTTON TIPPED APPLICATORS

Neat, uniform and economical, the cotton of these *ready-made* applicators is machine-anchored to ends of smooth, wooden sticks — may be sterilized without affecting anchorage. Quickly absorbent. 100 applicators in cellophane bag; 20 bags in carton. Two lengths — 3″ and 6″.



Johnson & Johnson
LIMITED MONTREAL

. . . . . *All the way!*

INDIVIDUAL DISPOSABLE

HYGIENE

SPUTUM CUPS

MOISTURE PROOF!
NON-CRACKING!
RIGID CONSTRUCTION!

READY FOR USE IN A JIFFY

Hygiene Sputum Cups come flat, fully scored. Automatically lock rigidly into usable form in a jiffy.

● Here's a cup that's made to stand up to rough handling and usage. Made of pure board, wax impregnated and wax coated, it won't leak or crack, holds its shape. Specify *Hygiene* Sputum Cups.

Other *Hygiene* products for hospital use include Hypro Kraft Towels, Hypro Toilet Seat Covers, Hospital Cellulose Rolls, Doilies, Tray Covers, etc. Ask your nearest branch of Hygiene Products Limited, for further information.

HYGIENE-PRODUCTS-LTD. HYPRO CANADA
PROMOTERS OF HEALTH

Hygiene Products
Limited

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MAKERS OF A WIDE LINE OF SANITARY PRODUCTS FOR HOSPITALS, SCHOOLS, OFFICES, INDUSTRIES, ETC.

Across the Desk

New Sales Manager of Oakite Products

Announcement is made by Oakite Products, Inc., New York, of the appointment of J. C. Leonard as Sales Manager of its Industrial Marketing Division. Associated with the Oakite organization in the servicing of its specialized cleaning materials and equipment for over 22 years, the last 16 years of which was in the capacity of manager of the company's Chicago's Division, Mr. Leonard assumed his new duties on September 1, 1946. He will direct the marketing and servicing activities of Oakite's industrial field staff from the general offices of the company in New York.

* * * *

T. M. Gibson's New Firm

Mr. T. M. Gibson, who is widely known to Hospital executives throughout eastern Canada, announces the formation of a new company, Thomas Gibson & Company, at 193½ Mutual Street, Toronto.

The company offers several unique innovations in the field of hospital sanitation. They feature a bowl cleaning and disinfecting service for toilet units and bed pan hoppers in hospitals, and in conjunction with this service they use a new Silicone product called Silicote. This is a clear lasting liquid protective film for all ceramic surfaces, plate glass and woodwork. It leaves an invisible glass film, which prevents soil from collecting on surfaces, and eliminates the necessity of frequent washing.

They also offer a new surgical soap Surgoplex, which is made by a soft oil process, particularly bland on surgeons' skin. They have too, a soft oil baby soap, which they say, is finding great favor.

(Concluded on page 20)

The Importance Of Confidence

• Reassuring the patient and gaining his confidence when oxygen is to be administered has an important bearing on the effectiveness of the treatment.

The physician's explanation of why oxygen is being prescribed and what beneficial effects it will have goes far toward gaining the patient's confidence and calming any fears he or members of his family may have.

But this confidence must be maintained. Therefore it is important for the nurse — by showing that she is thoroughly familiar with handling the apparatus and with the treatment in general — to continue to inspire this confidence.

Send for the 55-page "Oxygen Therapy Handbook," which describes mechanical technique and apparatus in detail. It will be sent without charge.

DOMINION OXYGEN (B.P.)

OXYGEN THERAPY DEPARTMENT

DOMINION OXYGEN COMPANY, LIMITED

DOC

159 Bay Street Toronto 1, Ontario

"Dominion" and "DOC" are trade-marks.

for schools

The steady tramping and scuffling of children's feet have little effect on a linoleum floor.

hospitals

Restfully resilient, linoleum absorbs sound and is easy to keep clean and sanitary.

stores

Clean, colourful linoleum adds to the display value of merchandise, while its foot-easy resilience appeals to customers.

offices

Smart in appearance, quiet and comfortable to walk on, linoleum wins approval of staff and clients alike.

practical floors

of lasting beauty and resilience

FOR the floors of public rooms, linoleum is the preferred choice. It can always be kept spotless, for it's quickly and easily cleaned. An occasional waxing, with light moppings in between, and it stays in perfect condition through the years.

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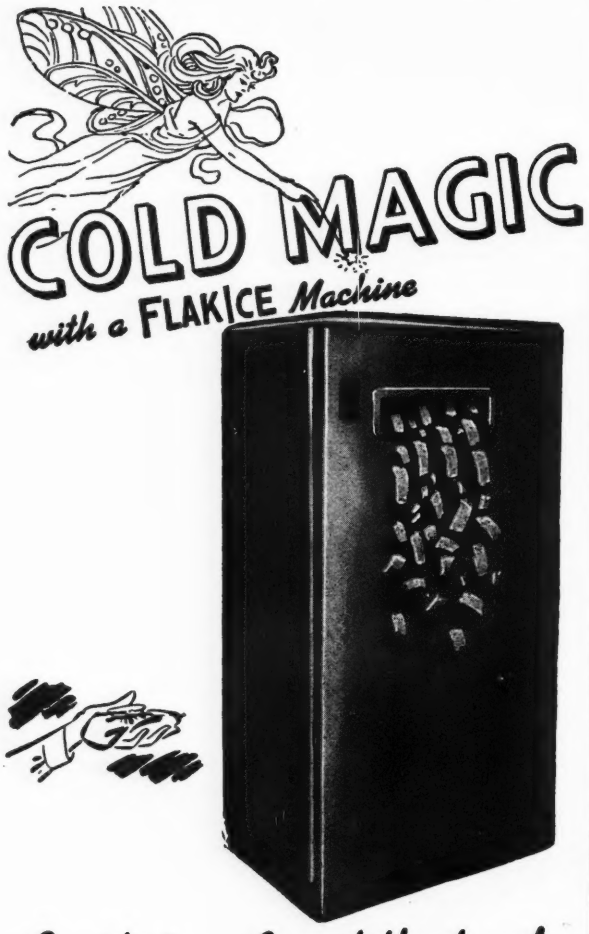

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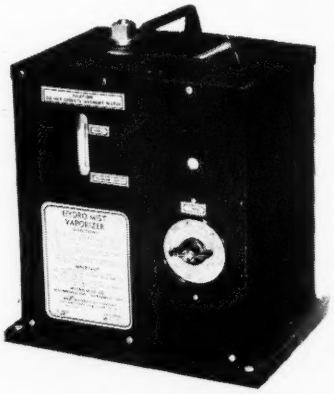

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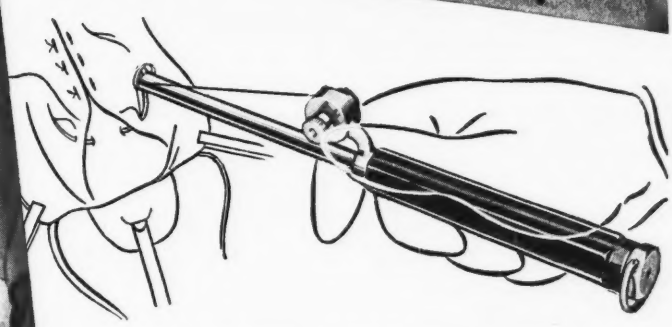

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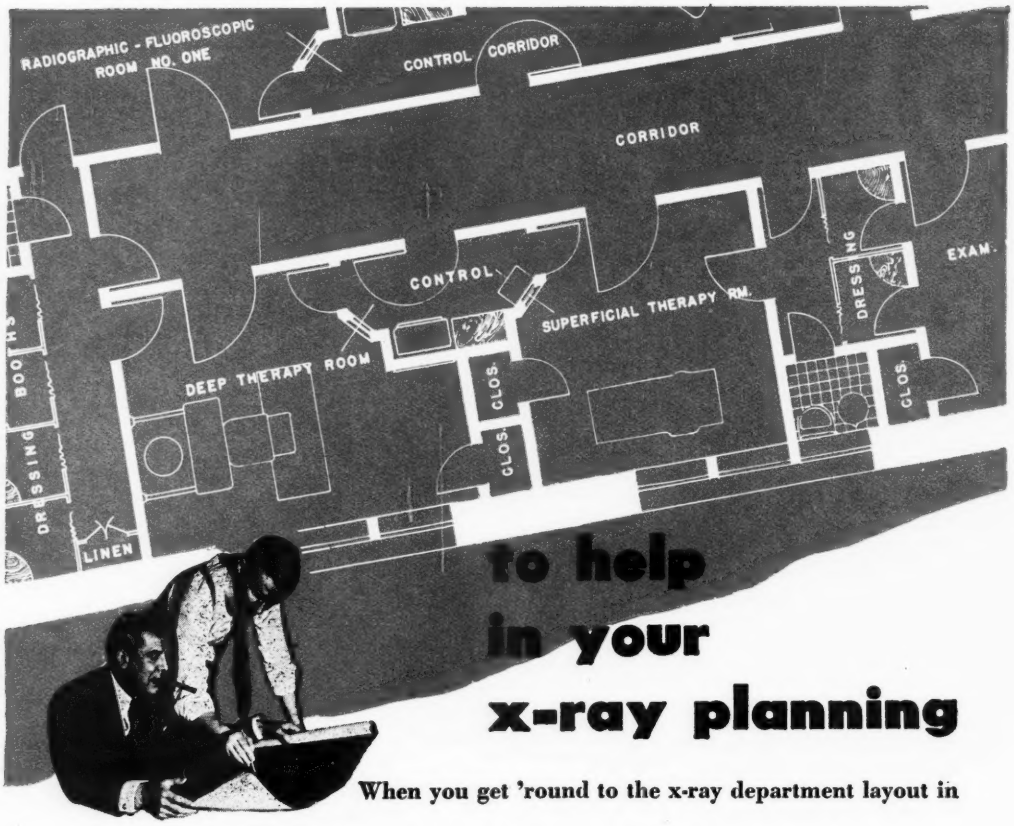

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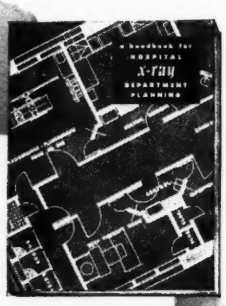

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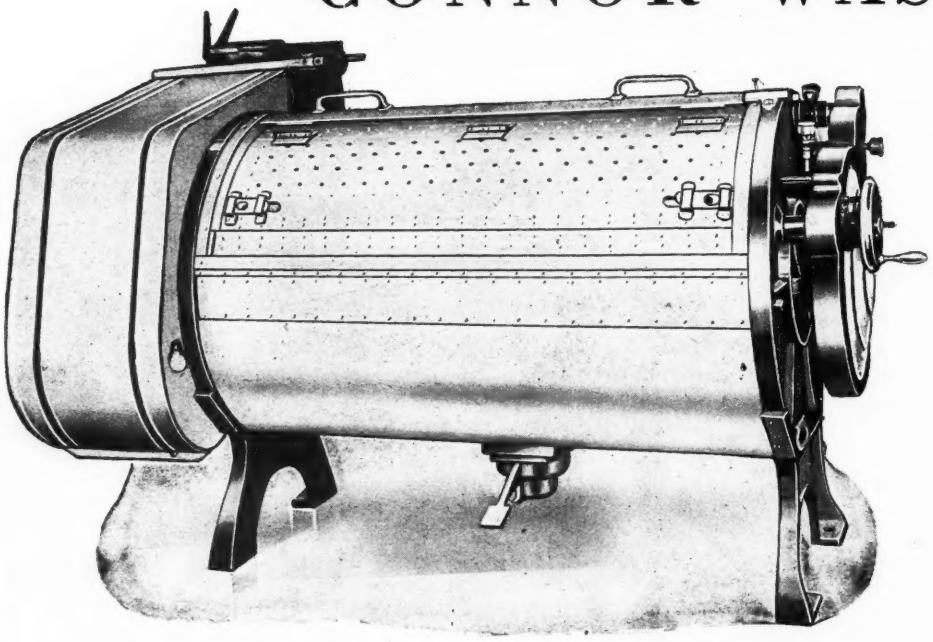

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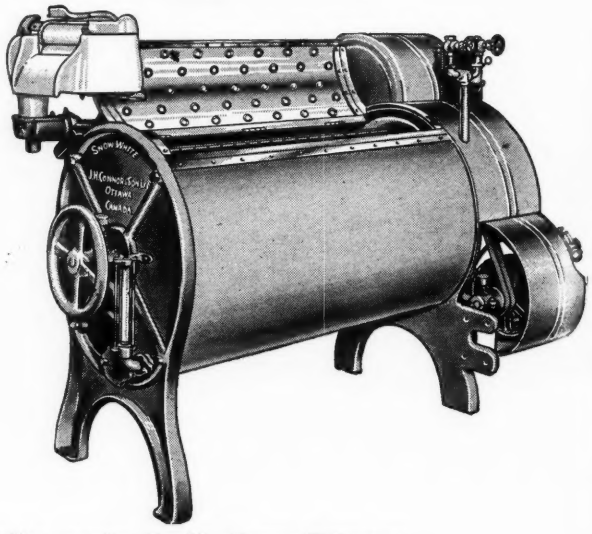

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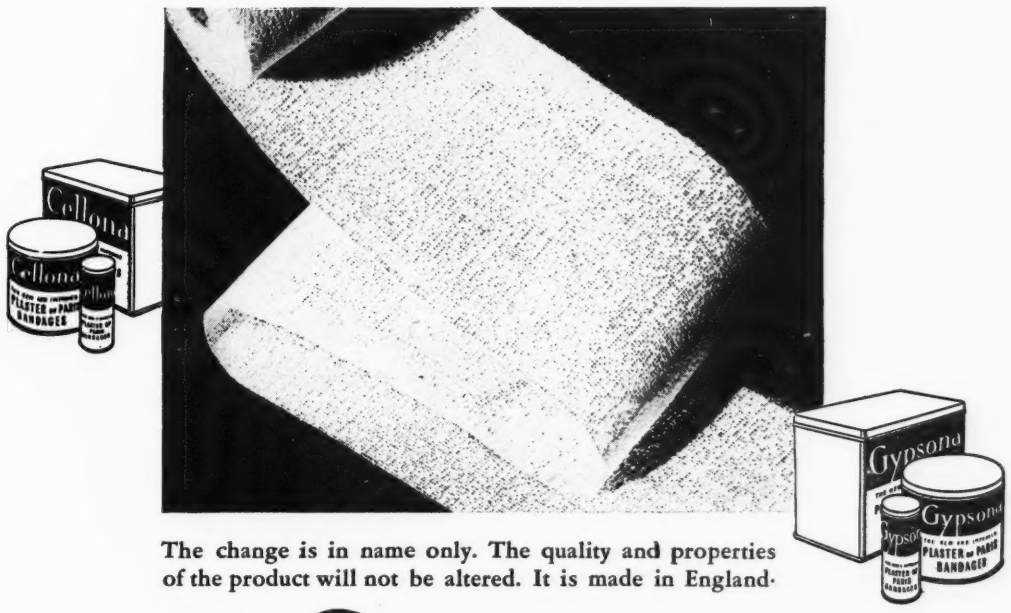

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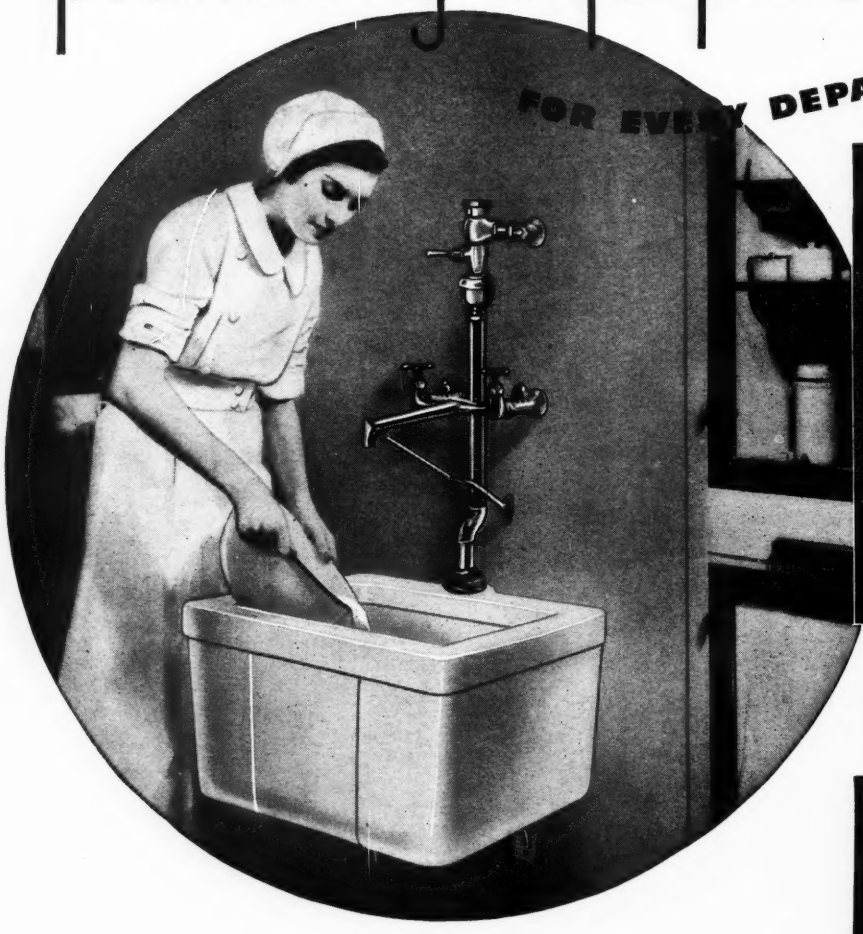

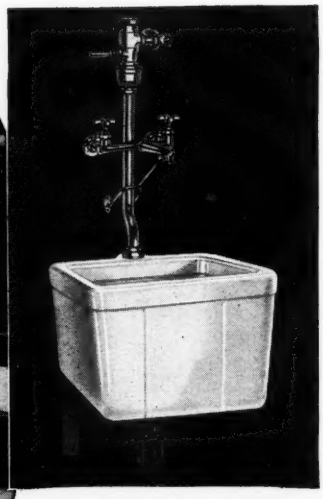

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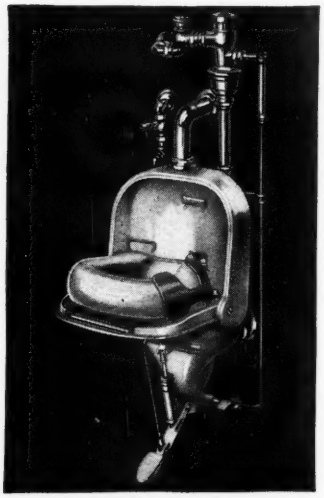

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Harvey Agnew, M.D., Editor

Toronto, October, 1946 Vol. 23 The CANADIAN HOSPITAL No. 10

Expert Opinions from Coast to Coast

To Build or Not to Build ?

By the Editor

THAT is the question. Some three-quarters at least and probably more of our hospitals would like to expand—in fact, *must* build soon if they are to cope with their community needs. Many of these hospitals have plans well advanced or completed; quite a number have the necessary funds collected and set aside for that purpose.

But there they stop. The nation-wide program of hospital construction as soon as the war would be over has bogged down, not completely but to such an alarming extent that the lack of beds is becoming more acute every month and our hospital facilities would be utterly inadequate should a national epidemic or even a major local catastrophe occur.

It is obvious from our correspondence that building committees are dismayed by the tremendous increase in building costs. They are disheartened by the alarming shortage of so many materials, steadily becoming worse as strikes continue and spread. They see the old wells of philanthropy drying up because of heavy taxes and shrinking upper incomes and hesitate to launch campaigns. It is over a year since the Federal Government announced low-interest loans for hospital construction, contingent upon a satisfactory adjustment of the federal-provincial taxing privileges, and still we must be patient.

Hospital boards are very much perplexed. With the steady development of diagnostic and therapeutic procedures requiring hospitalization, with the growth of Blue Cross, in-

Should we build NOW?

CAN we build now?

Will COSTS come down?

Would TEMPORARY Buildings be advisable?

dustrial and many other voluntary and commercial plans of hospital care providing hospital benefits and with the trend towards state-sponsored hospital care as now arranged in Alberta and Saskatchewan, more beds are urgently needed. Revised estimates of Canada's hospital needs compiled by this office (see Table on this page) indicate that our present total of 114,750 public beds and bassinets * should be increased at once to 153,760 beds and bassinets and by 1955 to a total of 173,560. In other words, we need 39,000 more public hospital beds and bassinets *now* and a further 20,000 over the next nine years—or a total of 59,000 more in that period.

Of course this is all tied up with the question of obtaining a sufficient staff to operate these hospitals and with the establishment of patient rates, provincial grants and municipal, voluntary plan and other payments at a level sufficient to maintain the hospitals.

Hospital Beds Needed in Canada
(as revised September, 1946)

These estimates are of the hospital accommodation required to meet our needs now and as they may be anticipated a decade hence in the light of present trends in social legislation.

Figures for active hospital beds are on the assumption that an adequate number of beds for chronically ill and (in larger communities) convalescent patients will be provided; otherwise the estimate of active beds should be increased.

	Present No.	Total Present Need	Total needed 10 years hence
Active	47,643	56,000	65,000
Bassinets	7,287	8,500	9,500
Chronic	3,185	13,500	16,000
Tuberculosis	12,060	19,560	19,560
Convalescent	900	2,200	2,500
Communicable Diseases	1,175	3,000	3,000
Mental	42,500*	51,000	58,000
Totals	114,750	153,760	173,560

***On December 31, 1944, there were in residence a total of 47,279 inmates. In addition, 3,968 were on parole and 529 were boarding out, a grand total of 51,776. This does not include the extensive waiting lists or the many for whom admission would be desirable.**

NOTE:—This table does not include the Dominion hospitals; there are 533 beds and 41 bassinets for Indians, 19 beds for lepers and several marine and quarantine hospitals; the many and large D.V.A. hospitals and the numerous Department of Defence hospitals are not included. Nor are the 3,821 beds and 758 bassinets in proprietary (or private) hospitals included. As public hospital facilities expand and extend to new communities it is anticipated that the need for private hospitals and their use will diminish.

Expert Opinions Obtained

In an endeavour to obtain the most reliable composite opinion, enquiry was made of a number of leading contractors and hospital architects from Victoria to Halifax. Their views were remarkably uniform.

Availability of Materials

On this point there is complete agreement: materials are in short supply. The President of the National Construction Council of Canada states, "Materials will be in extremely short supply for two years, but would be obtainable with government priority help". This includes steel, lumber, flooring, lath, cement, brick, electric wiring, nails, soil pipe and black iron pipe. In the east plumbing fixtures and fittings are very scarce, whereas a reply from British Columbia indicates that these and other plumbing equipment are now becoming more available. A reply from Victoria indicates that "lumber available is spread over so many projects that no one gets sufficient". The same architect notes that gyproc is heavily rationed and that linseed oil is now off the market.

How long this shortage of materials will last would seem to be a matter of opinion, or of regional conditions. One contractor thinks an economist would be better able to make an estimate. A number of contractors and architects blame the strikes for the present situation in large part and are pessimistic about any early improvement in the situation because of the possibility of further strikes taking place. Because of this situation the lag in delivery is now extending into many months after receipt of order. An Alberta contractor anticipates that a number of closed brick plants may be reopened in the near future and that there should be better deliveries of cement in 1947. Vancouver opinion is that "the material situation is bound to improve from this date on". Using lumber as an illustration he believes that the establishment of parity between the Canadian and American dollar has helped considerably to reduce exports to the United States, with subsequent benefit to the domestic consumer.

One contractor considers that conditions could not be much worse and, therefore, "we can reasonably anticipate that we are at or closely approaching the peak of our difficulties and an improvement in the situation may be expected in the not too distant future . . . The situation could change for the better very quickly."

An architect of much experience writes:

"There is abundant evidence that manufacturers are studying many new materials and improvements in the use of existing ones.

"The longer hospital boards can keep out of the present scramble for what is available, the greater the possibility of getting more efficient building."

Hospital Priority

In several replies received it was stated that hospital construction should be given some priority. When one notes the number of stores, theatres and other buildings of secondary importance to community

**Based upon 1944 reports compiled by the Dominion Bureau of Statistics. Department of Veterans Affairs and other Federal hospital beds not included.*

existence being erected, there seems to be considerable point to this suggestion.

The head of a large building and engineering firm in Montreal makes the following very helpful comment:

"It has always been my thought that in these present years of post-war reconstruction, the efforts of the whole construction industry should properly be devoted to getting first things done first. The capacity of the construction industry is limited first by the number of skilled craftsmen available and second by our capacity to produce necessary materials. We know that in the peak war years 1941 and 1942, the construction industry demonstrated the capacity to handle work at the rate of around six hundred and forty millions per annum.

"In my judgment, a pretty sound and conservative expectation is that in the first five years of post-war reconstruction, the construction industry should be able to develop an annual turnover of six hundred millions, which would mean a total capacity of three billions of dollars in the first five years.

"If in these first five years of post-war reconstruction we figure on building a total of 200,000 new living units at an average cost of $5,000.00 each, it will be seen that we shall need $1,000,000,000.00 for housing during the five-year period in question, leaving two-thirds of the total capacity, or $2,000,000,000.00, for other work.

"Out of this remaining two billions, my conviction is that we should devote a substantial part of the capacity to other "musts", like hospitals and schools. You will know better than I do what this proportion should be. It might be an average of, say, two hundred and fifty millions per annum for the country as a whole, or perhaps even more than that.

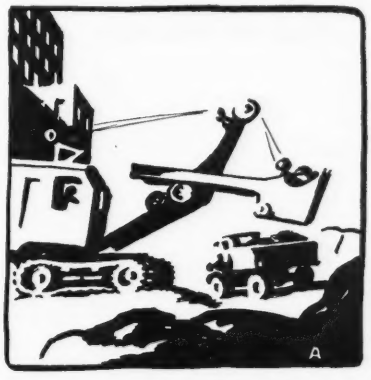
"The balance I would direct to the execution of industrial and commercial work promising the greatest measure of new employment.

"In other words, my feeling is that the efforts of the construction industry in at least the first five years of post-war reconstruction ought properly to be concentrated on the production of the simpler types of housing accommodation, on hospital and educational facilities and on new employment-providing industrial and commercial developments."

Quality of Labour

While several replies indicated that the quality of the labour available was quite satisfactory, the majority of the replies indicated that the quality was below standard. One writer stated that he had found that the best men were the older men; some of the trades had taken in very few apprentices in the past decade or two with the result that many of the younger men now required in these trades were comparatively untrained and unskilled.

In most parts of Canada there is a shortage of all types of labour and particularly of skilled labour. The biggest shortage would seem to be in the trowel trades—bricklayers and plasterers.



One significant quotation:

"The decrease in efficiency is not altogether due to the dilution of less skilled men in the total employed. To a very noticeable extent the performance of *skilled* men has fallen off and we feel very strongly that this is a matter which the unions should be active in remedying."

Commenting on the present high cost of construction, a contributor to *Engineering and Contract Record* states: "(a) Another quite serious cause is the fact that in practically every unit cost examined on jobs today the production per man per day is below that of the very same individual's performance some years ago to a fantastic degree." The contractor with whom we discussed this factor of slow-down, which has become so serious in a number of industries during the past few years, stated that in the "good old days" his bricklayers used to lay a thousand bricks a day on a straight run. Now he is fortunate if he can get two hundred bricks laid a day. On the other hand, he noted that in his city if bricks were to be laid on a contract basis by the bricklayer himself the prevailing contract price was $30. per thousand; the bricklayer then can lay his thousand bricks a day, except for intricate work.

Will Costs go Up or Down?

Most replies indicated a definite fear on the part of both contractors and architects that the costs of construction would continue to rise for some time. "We are in a rising trend which will continue until there are sufficient materials to meet the demand. An adequate supply of materials even without a reduction in prices will substantially reduce overall building costs by allowing greater efficiency as well as lower overhead charges." From the Maritimes one writer is of the opinion that costs will rise for at least five years. A Prairie observer believes that they will rise but eventually will be stabilized at approximately present day levels. Several anticipate that the possible removal of price ceilings to a further extent will have an upward influence on costs. A contractor of wide experience states "unless organized labour makes it impossible, we should at least be able to hold the present line where costs are concerned, with the reasonable expectation that as more skilled men are trained in the apprenticeship and vocational training institutions which have now been set up from coast to coast, the average production capacity of the construction worker will be increased, resulting in a corresponding lowering of labour costs." A Prairie contractor is of the opinion that further wage increases may be offset by the greater availability of materials in the future "as the hand-to-mouth condition with regard to materials always increases the labour costs on these materials". A western architect thinks that any increase in labour costs above their present level will so increase the cost of construction that the building of any class of structure for an investment will cease.

In anticipating that costs will come down, one western opinion is that as soon as the military credit and bonds held by many people are liquidated into homes, furniture, business, etc., and the free money absorbed, people will be seeking work again and with it prices will come down and efficiency will be increased.

Should Construction be Permanent or Temporary?

In the light of present conditions should hospital committees, if they must build now, proceed with permanent buildings or should construc-

tion, generally speaking, be on a temporary or semi-permanent basis?

On this point there was very definite unanimity; only permanent construction should be undertaken.

In the opinion of one West Coast architect, once a building is erected as a temporary measure it remains as such for years to come; when the time comes to demolish such build-

ing the combined costs of the temporary building and of the new and permanent structure to replace it usually indicates a higher cost than if a permanent structure had been erected in the first place. Another writes, "I feel that permanent rather than temporary buildings should be constructed, cutting down the program to meet the present situation and finishing the structure or program when times and conditions are on a sounder and established basis. Temporary buildings over a period may eat up present extra constructional costs by added maintenance and repairs." A contractor notes that "materials that are in the shortest supply would be required for a temporary hospital to almost the same degree as for a permanent one."

An eastern architect of wide hospital experience states:

"It is difficult to determine the difference in cost between temporary and permanent construction. Furthermore, it is not practical to build temporary construction for any large hospital development. It would require a very large site, as such buildings should not be more than one storey in height and the resulting costs of operation would be more than in a multi-storied permanent building.

"It must be realized that the only saving in such construction is in the walls, floors and general basic parts of a building. When the finishing trades are reached, i.e., plastering, roofing, painting, flooring, plumbing, heating, electrical work, cupboards, doors, etc., there is no substantial difference.

"In considering temporary construction, it is assumed that the basic structural material above the ground would be wood. It should, therefore be kept in mind that the quality of this material that has been available during recent years, and is likely to continue for some time to come, is greatly inferior to pre-war stock. This will most likely cause, through shrinkage and consequent movement, considerable cracking and opening of joints, thus providing crevices impossible to clean.

"The cost of maintenance in a temporary building will be much more than in one of a permanent nature. Consequently a community investing in a temporary building may not find the initial cost as low as hoped for and in ten to fifteen years will be called on to replace the structure with another of more permanent nature. The cost at that time may be less than at present, but the total outlay will undoubtedly be greater. Furthermore, there is no assurance that the community will be in as good a financial position to replace the building at some future, as it may be at the present time to build a permanent building, even though the cost may, judged by the depression costs of the 30's, be very high."

An eastern contractor calls attention to the fact that temporary construction costs are much higher than for the same construction in the past. He writes:

"When lumber could be bought for less than $25.00 per M. and good skilled labour was in plentiful supply, there was some argument for the temporary building. However, with the labour situation as it is today and with material costs as they are, there is really very little justification for erecting temporary hospitals anywhere. Such buildings have to be protected against fire hazard and fire-fighting apparatus costs money. Probably the only argument for the temporary hospital is the lack of bricklayers; that is an obstacle which will be overcome in time, and there is no gainsaying the fact that for the moment the capacity of the construction industry to produce buildings like hospitals which call for the services of a large number of bricklayers, is definitely limited."

One western architect did favour a semi-permanent type of construction:

"Considering the above factors (shortage of materials and of skilled labour and a likely ascent in costs) and also the fact that hospital planning is in a continual state of flux, I believe that buildings in the immediate future should be of semi-permanent construction, and further, they should be designed in such a way that interior changes are possible without a great deal of construction work. This might be obtained by the use of light steel frame construction. Where land is easily available, my view is that this type of hospital should be not more than two stories in height and that basements be eliminated as far as possible."

(Concluded on page 84)

Federal Report on Costs of Construction

As we go to press Reconstruction Minister Howe has released a study on building costs prepared by the Department's Economic Research Branch. Highlights of this report indicate:

Between 1939 and 1945 the cost of building materials was increased by 42 per cent, wages by 31 per cent (weighted average, 37 per cent) and costs went up another 10 to 25 per cent because of lowered efficiency and delays; in all an increase of 47 to 62 per cent.*

The report indicates that further and almost immediate increases in building costs may be expected. Costs cannot be reduced until efficiency in building operations is increased. "But part of such a decline might be offset in the immediate future by a further rise in prices of building materials and wages paid to construction workers."

**Since then there have been further substantial increases. Builders believe, too, that still higher figures might have been quoted if the substantial additional expenses of contractors, because of the endless search for moterials and other factors, had been included. Moreover, this report deals with housing; in that field much of the work is done by workmen at lower wages than are uniformly charged for hospital and other large scale construction.—Edit.*

An Experiment in Personnel Relations


HERBERT R

OBSERVING EYE

Mrs. S.E. Rutherford, Editor. Vol

We are proud and pleased t
elected President of the Lion
27th, 1946.

A FAREWELL

H. C. Allnutt,
Superintendent,
Herbert Reddy Memorial Hospital,
Montreal, P.Q.

SINCE March, 1945, fortnightly meetings have been held at the Herbert Reddy Memorial Hospital which may be loosely termed "Supervisors' Meetings". They are not to be confused with department head or staff meetings nor do they replace conferences between department heads and the administrator; they are additional and supplementary to these.

Their inauguration was prompted by a specific problem; but they could be of value under other conditions. In the latter part of 1943, the administrative policy of the hospital was completely changed and with it the nature of the institution itself—the type of patient, the diagnostic facilities, the training program, etc. The meetings were, therefore, started as an integral part of a program to enlist the aid of the entire staff in assisting the administrative body to achieve its objective. The motivating idea was the need for intelligent co-operation from all. If knowledge creates understanding, this seemed a suitable instrument with which to disseminate it.

The meetings are attended by the superintendent of nurses, the office manager, the dietitian, the senior technicians from the x-ray department and laboratories, the record librarian, the pharmacist, the director of the outpatient department, the purchasing agent, the engineer, and laundryman, and are presided over by the superintendent.

There is only one inflexible rule—no criticism is permitted of a department the representative of which is unavoidably absent.

There is no time limit. On occasions the meetings, which start at 3 o'clock and are held on Wednesday as the least busy day of the week, have lasted for two hours. In other words, interest is the yardstick by which the discussion period is measured. There is a secretary and minutes are duly recorded.

Frankness is encouraged and the Chair seldom needs to intervene. Voting on any decision is taken by a show of hands and the same procedure is followed for the appointment of sub-committees, whose members may be chosen from among the staff, irrespective of their position. Incidentally, committees are used as much as possible and it should prove of interest to note that the administrator never attends committee meetings.

Two guest speakers have appeared. Mr. Walter Hatch, administrator of the Homoeopathic Hospital of this

A Supervisors' Meeting

The Engineer has just finished explaining—with the aid of the blackboard—what losses result from leaking taps and fixtures. The Superintendent is presiding.

The Herbert Reddy Memorial Hospital
Formerly known as the Woman's General Hospital

city, spoke on "Legal Aspects of Hospital Administration" and Dr. Harold Griffith, medical director of the same hospital on "Technical Services", a subject on which he had presented a paper at a sectional meeting of the American College of Surgeons in March 1946. This experiment proved very successful and it is planned to invite other guest speakers in the fall, amongst them the president of the hospital and the chairman of the Public Relations Committee.

Further tangible results have been some excellent papers prepared by the representatives of each department on their procedures and problems.

At one meeting a discussion was held on a lecture delivered by Dr. Lydia Giberson at McGill University, as part of a series on various aspects of supervision. This produced two papers which showed considerable effort and thought on the part of the members who presented them.

The publication of a staff newssheet called "The Observing Eye" also developed from these meetings. The formation of the editorial staff, the name, etc., were left entirely in the hands of a committee who referred its recommendations to a general meeting. The character of this paper has gradually changed with the months and now it carries staff directives as well as staff news.

A fund-raising tea proved to be an unqualified financial success and, on the recommendation of the committee handling it, the proceeds were placed at the disposal of the nursing department for the purchase of books for the students' library.

A course of job instruction has been given under the Federal-Provincial Youth Training Plan and in order to stress the fact that it was a scheme for improvement from within, voluntary and not imposed, the details were again left in the hands of a committee.

Recently another innovation was introduced. This is a five minute period during which the Chair answers any question on subjects affecting the future policy of the hospital. This was inaugurated mainly because occasions are bound to arise, however well informed one may keep one's staff, when some change in policy or procedure is inadvertently missed.

The true measure of the success of such a venture, however, rests on intangibles and it would indeed be presumptuous on the part of any individual to make no qualification in assessing the results. There must be unrelenting effort and a degree of patience which at times is difficult to maintain but the writer feels it is worth both; some seed must fall on fruitful ground.

Perhaps it would be fitting to borrow the phrase printed on the cards issued by the Youth Training Plan as a final word of advice and warning—"If the learner hasn't learned, the teacher hasn't taught".

James Keber Lindsay, M.D.

The medical profession in Canada and in Saskatchewan in particular, suffered a grievous loss in the death on August 14th of Doctor James George Keber Lindsay, registrar of the College of Physicians and Surgeons of Saskatchewan. Although only in his early forties, Doctor Lindsay succumbed within a week following a coronary thrombosis.

Born in North Bay, Ontario, he was graduated in medicine from Queen's University and interned at the Vancouver General Hospital. For a number of years Doctor Lindsay practised at Lumsden, Saskatchewan, returning in the winter months to lecture at his Alma Mater. He became registrar of the College of Physicians and Surgeons in 1936. Enlisting early in the war, he proceeded overseas with No. 8 Canadian General Hospital as registrar. In December, 1944, he was posted as Officer Commanding No. 3 C.C.S., and in April, 1945, became a full colonel and Officer Commanding Roman Way Convalescent Hospital. On discharge in December, 1945, he resumed his former position as registrar in Saskatchewan. He is survived by his widow and five children.

Doctor Lindsay was exceedingly popular, both with the profession in Saskatchewan and with his colleagues in the services. He was taking a very active part in the formulation of sound policies, both in his own province and nationally, for the development of health insurance measures, and had gained to an unusual degree the confidence and respect of all with whom he had to deal. To his family and his mother we offer our deepest sympathy.

Some Thoughts on

Socialized Health Services

and on

Social Medicine

R. P. VIVIAN, M.D.,
Strathcona Professor of Health and Social Medicine, McGill University, Montreal.

PEOPLE everywhere are deeply concerned about illness and its cost. It is being emphasized in public discussion. Responsible governments are attempting to meet the public demand through legislation and to provide the necessary money. Caution is required.

One of the dangers of a period like the present when progress in social thought and development is enormously accelerated is a general tendency to exaggerate the importance of *speed*. People are so afraid of losing the bus that they tend to leap aboard without making sure of its destination and without even being certain that all their necessary luggage is with them.

The danger lies in the adoption of insufficiently considered plans with all their implications. The danger is real as regards both services and cost. As an illustration, I refer to the reportedly unhappy experience in New Zealand with its system of health insurance. Articles now appearing, which I have not seen denied, are stating that the service, as it exists, is far from complete in character or extent, that the cost is bearing very heavily upon the taxpayers, and that the reputation of the medical profession has been seriously impaired.

In using this illustration I do not wish to belittle in any way the attempt of New Zealand to find an answer to some of the most pressing and perplexing problems in the practice of medicine. Nor do I deny the need for tax-obtained money to support good health services.

There is also danger in believing that a type of medical practice successful in some other country or even in another area of the same country may be generally applied with equal success.

In estimating the value of any health plan we must consider the character and knowledge of the people in the area, the type of service previously in effect, the medical standards of personnel and facilities, and the reliability of the statistics. We do know of tax-based programs that are successful both as regards service and cost. The success of these plans, in my opinion, can be directly attributed to the character of the people and their knowledge in matters of health. I am, however, inclined to believe that one of the plans most persistently advertised as successful in a country lacking freedom of speech, freedom of the press, and freedom of unbiased investigation is little more than the rosy-hued story of the setting up of *something* where nothing previously existed.

The interest of the public lies mainly in how to obtain curative services at less cost to the indivdual.

On this continent there are successful tax-based medical care programs of limited character that suit the region for which they are designed. Additions to these programs would improve the scope and quality of the service. The whole could provide the maximum possible for the areas concerned. In certain localities this system should prove to be excellent. If such a plan were wholly transplanted, it might suffer the fate of so many transplants—death from inanition in foreign soil because the ingredients for success were lacking in the new surroundings.

A tax-supported plan for medical care presents many problems. In my opinion, it must be sufficiently flexible to be adaptable to the varying conditions encountered. It must maintain the highest standards in medicine. It must not place an undue burden upon the tax-payer who is able to maintain a good state of health. It can only be effective if all the services that are required are adequately co-ordinated. The practice of medicine is really dependent upon the fullest development which can be made in each of its component parts. These are not only curative medicine, hygiene and prevention, but also the broad field of social welfare. Social welfare is not merely the doling out of charity under another name from the tax-payer's pocket. It should be the means of attaining further advances in the progress of society as a whole. It can aid substantially in the program for man's betterment. We have seen for some time a growing interest in social welfare that belies the traditional statement of man's inhumanity to man. It began as so many worthwhile things have begun, through voluntary organization. It is now officially recognized as a responsibility of government by means of legislation and the allocation of tax money for this service. Many of the gaps that need to be filled in the services of curative medicine and public health could be aided by developments in the field of social welfare.

Medical Economics

The medical problem of today

From an address on "Medical Problems of Today" given at the Lake Louise Convention of the American Pharmaceutical Manufacturers' Association in June.

may, therefore, be simply expressed by saying that it represents the need for the fullest development of all the branches of medicine and their effective co-ordination to achieve the objective as defined. Each branch of curative medicine, public health, and social welfare, has a definite part to play. Each is dependent upon the other for the fullest development in its own field. All are dependent upon the provision of money, frequently from tax-collected funds. The provision of money for the payment of health services comprises the subject of Medical Economics. There is nothing mysterious about the subject of medical economics except the failure of some otherwise well-informed people to understand that the practice of medicine costs money, in fairly substantial amounts. Many people are today alive and reasonably well because of the advances of medical science which are justifiably costly in application. The lowering of medical standards or a reduction of service because of the cost is poor medicine and bad economics. This cost is, however, frequently more than the ordinary individual's pocket-book can meet without seriously affecting the family budget. Adequate medical care is sometimes foregone because of the economic barrier of cost to the individual.

Medical economics cannot be considered as an isolated subject. It must be thought of in relation to the entire economy of the local community and of the state. The provision of vast sums of money for health from tax sources is one thing. Its provision in relation to the economy of the state is quite another. The wise provision of suitable sums and their careful expenditure in relation to value received should certainly be the objective.

These services cannot be provided solely on a treasury-minded basis, namely, a cash surplus. Neither can we jeopardize the entire economy of a country by providing, for purposes of political expediency, an ineffectual program at great cost. The need to do something, however, is urgent. Much could be done by adapting our present resources. The adaptation of our facilities and the training of personnel can only be achieved if we expand our interpretation of the practice of medicine. For obvious reasons we have been concentrating upon what we could do for disease as an entity. Man, however, is not something set apart. He belongs to a family, or a group, or a community. In treating man's diseases we must, therefore, consider man as a social being and take into account those factors in society which play an important part in his well-being. The future practice of medicine will be greatly benefitted by what it can learn from a study of sociology in relation to medicine.

Social Medicine

Such thought has given rise to the development of a new branch of medicine, a branch which concerns itself with the study of the social factors that influence the attainment and maintenance of health. This new branch, social medicine, should not be confused with so-called socialized health services. Social medicine may be new as a subject but it is not new as an interest. Its task is to show how all the services in the practice of medicine can be developed and co-ordinated in relation to society. We have limited examples of the effectiveness of some co-ordination. The story of tuberculosis is one. In Canada tuberculosis is now 7th in the 10 leading causes of death; in 1933 it was 4th. The reduction in the incidence of this disease has been achieved by the establishment of facilities and the presence of competent and well-trained personnel, methods of case-finding and treatment, and financial support from voluntary contribution and government grants. The whole has been brought about through education of the public.

Technology and Medicine

Hardly any other field of science is as misunderstood as medical research. The public usually envisions a physician suddenly conceiving a new idea at the sick bed. He makes a few experiments, preferably on himself. At first he is not believed; then he cures thousands of people! Medical research does not follow such a course. It is usually a slow and painful piecing together of unspectacular material derived from many sources.

In the past, chemistry has played an important role in medicine whereas the participation of physics has been relatively limited. Many physical agents employed in medicine are nonspecific in action; hence their value has been minimized. Also physical agents have been little employed in medicine in the past simply because physics is too difficult.

Now a decided change in the use of physical agents in medicine has occurred. New technical and theoretical means of research in physical medicine are available.

There is much evidence of the desire to make the results of recent physical and technologic investigations available for the service of biology, medicine or public health. The newer approach in physical medicine involves a quantitative study of the effects of the various physical phenomena acting on the living organism and investigates step by step the results of these actions. Physical and technologic research may brilliantly complement clinical observation in furnishing the guiding principles for supplying medical men with new equipment.

To establish effective liaison between physics and medicine, not only must the physicist know more about biology and medicine than he has in the past, but the physician must employ the physical way of thinking and must acquire knowledge of available physical technologic methods.

—A.M.A. Committee on Physical Medicine.

Preview of Surgical Films

In order to provide Canadian doctors and surgeons with an opportunity to review recent additions to the D & G Surgical Film Library Davis & Geck, Inc., Brooklyn, New York, is presenting a preview of these films, to be held at the Eaton Auditorium, Toronto, Ontario, on October 25 at 8:00 p.m.

Reservations may be secured by writing to Davis & Geck, Inc., Box 508, Toronto.

St. Thomas's, London

- - - A Pattern for the Future

ST. THOMAS'S HOSPITAL, the beautiful range of buildings on the Albert Embankment, facing the Houses of Parliament in London, which plans to make itself the most up-to-date hospital in Britain, is linked through its students with most countries of the world.

St. Thomas's dates from a small convent built on the banks of the Thames more than sixteen centuries ago by a charitable woman. The convent became a priory with provision for the sick and the maimed. But the removal from the streets of "poore and impotente people, offending every clene persone passing by the way with their fylthy and nasty savors" seemed a greater argument in the Middle Ages for maintaining and extending the activities of St. Thomas's than pure charitable reasoning. The drugs and other "cures" employed baffle description and as to discipline, the hospital has a record of the administration of twelve lashes "to be well laide on" to one of the nurses found drunk on duty.

The present St. Thomas's, of which the foundation-stone was laid by Queen Victoria in 1868, became the pattern on which most modern hospitals are built. Its reconstruction scheme will provide the pattern for hospitals of the future.

Not content with a history and a war record which would assure its immortality, St. Thomas's is looking to the future. War damage has to be made good. The hospital was hit by eleven heavy calibre bombs, one flying bomb and a land-mine—missiles undoubtedly intended for the Houses of Parliament across the river. Eleven members of the hospital staff were killed, and extensive damage inflicted on the buildings. But the hospital carried on, never lost a patient through bombing and treated thousands of casualties from the neighbourhood.

The Court of Governors has now considered and approved a scheme for the reconstruction of St. Thomas's with eight hundred to a thousand beds. Additional floors are to be added to the four central blocks and a new block of operating theatres will be built.

One of the novel features which will be considered is the possibility of heating the hospital by water from the Thames. It is a well-known scientific fact that flowing water contains heat. Water, it is hoped, will be sucked by pumps from the Thames into the hospital's heating installations, go through special apparatus, and, after heating the hospital, be returned to the river colder than when it left it. The use of the heat in flowing water effects considerable economies in fuel and electricity costs. Indeed, it is estimated that three to four times the heat contained in every unit of electricity applied to "pre-heated" river water is made available in radiators.

Another novel feature it is hoped to introduce is the "electric duster". The electrostatic air-cleaning system which hospital experts are investigating charges the particles of dust in the atmosphere with electricity so that they are magnetically attracted into the cleansing receptacles. Described simply, the main feature of the "electric duster" is a magnetized plate over which ventilating air is made to flow. The dust particles in the air, on reaching the magnetized area, become charged and are attracted to the plate. Some sort of false bottom is provided into which the dust particles fall, and periodically the current is switched off and the false bottom emptied.

In the proposed new hospital the wards will no longer consist of long rows of beds in a single room. The wards will still retain their great height, giving light and cross ventilation, but they will be divided by movable partitions, anchored in aluminum pillars, giving any size of ward required. The seriously ill can enjoy the quietness of the single room, moving as they recover to the cheerful gregariousness of the semi-convalescent wards.

The patients of St. Thomas's will enjoy one of the finest views in London from specially built sun-rooms looking onto the Thames and the Houses of Parliament. A new type of bed which will move lightly and noiselessly is being designed and

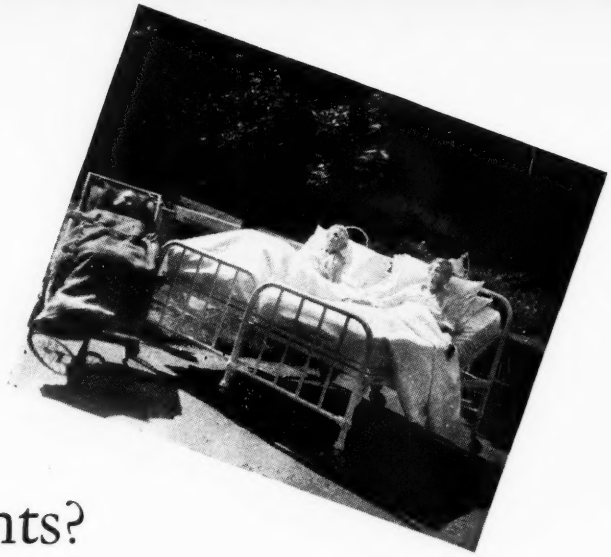
(Concluded on page 108)

St. Thomas's Hospital was hit by bombs probably intended for the Houses of Parliament seen in distance across the Thames.

—Photograph from "Hospitals Under Fire", by Geo. C. Curnock, George Allen and Unwin Ltd., Publishers.

Condensed from an article by Harry Gregson and supplied by the United Kingdom Information Office.

Clearer Thinking Needed in Dealing with the Longer Stay Patients



What do we mean by CHRONIC Patients?

By Pearl Morrison, Reg. N.
Superintendent, Queen Elizabeth Hospital, Toronto.

A GREAT deal is being said and printed these days about chronically ill patients taking up too many beds in active hospitals. We hear a lot about how much more cheaply a hospital for the long stay patient can be built and maintained than a hospital for acute illness. We are often told what little care the "chronic patient" needs. Some even go so far as to state the small amount it should cost to care for the chronically ill patient without endeavouring to check their estimates by consulting those who are actually providing such care.

I would like these writers to come to this particular hospital (the largest and oldest hospital for the chronically ill in Canada) and observe—and perhaps experience—the amount of care needed for our patients.

Different Types of Hospitals are Needed

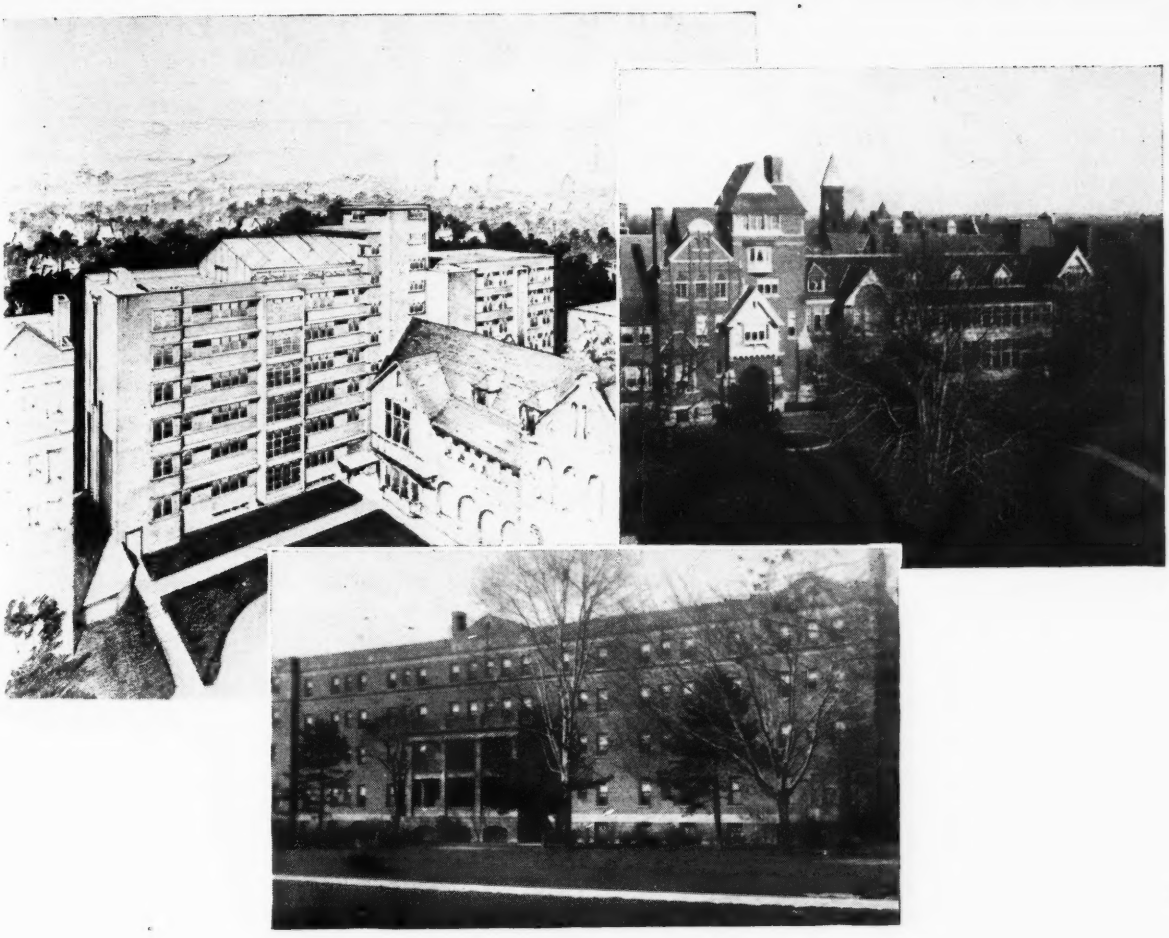
It would seem that these same "authorities" classify everyone who is physically incapacitated or who is occupying an active hospital bed, when he should be elsewhere, in one group. Actually these patients who "clutter up" active treatment hospitals should be in a variety of places, but one doubts if half of them rightfully belong in a hospital for the chronically ill. Some people go so far as to call simple old age a chronic illness; a person cannot always be young and vigorous. Some are surprised that a hospital for chronic diseases declines to admit a patient with uncomplicated arteriosclerosis. Many wish to use the hospital for chronic diseases because of social conditions at home, rather than *the medical necessity of the patient,* which should be the only reason for admission.

The active treatment hospital should be for the acutely ill patient of course, but why expect to put every other kind of patient in a hospital for chronic diseases? We need more homes for the aged and senile; for the crippled younger people who do not need a hospital but are in need of a certain amount of assistance; for the convalescent from both active and chronic hospitals—in order that the hospital for chronic diseases may be used for long-stay patients who *need* to stay *long.* Some, of course, are admitted who would seem to need a bed for a long period, but who rapidly and unexpectedly improve. There should be some place for such patients to go when such improvement is established, that another patient may have both his bed and his opportunity.

Why expect to solve a problem by attacking it in the middle? Why spend time collecting statistics on how many more acute patients might occupy the bed of a chronically ill patient in an active hospital were that chronically-ill patient removed to a hospital for chronic diseases, if that patient merely needs a home? If a home or its substitutes were provided for those who do not really need hospital care of any kind, this problem of shortage of beds in both active and chronic hospitals might be materially clarified. If the only handicap to living in a home is a stairs, then a place must be provided without a stairs, or with an elevator. Surely this is easier—and certainly cheaper — than providing hospital for those who do not need such expensive care.

We must keep in mind the patients who need our limited beds in a hospital for chronic illness indefinitely, and in so doing keep us from ac-

We hear much today about "getting rid of" the chronic patient in the general hospital. How many kinds of chronically ill patients are there? Do they deserve good care, too, or merely custodial neglect? Miss Morrison is tired of having people brush off the chronically ill and misunderstand the function of her type of hospital—and says so, too.



mitting other chronically-ill patients. Why are the walls of the hospital for chronic diseases expected to be more elastic than those of a hospital for acute illness? Certainly if active beds are not vacated fast enough for the need, how could we hope to vacate beds in a hospital for chronic diseases fast enough to assist the active hospital when the turnover is much, much slower, and the beds always full? Hundreds of beds could be provided yearly and still be full, if no thought is given to those most in need of these beds. Only when this is realized and the proper steps taken to provide different types of institutional care—or home care for those who need just that—can space be made in the chronic hospital to relieve the active hospital.

Above—The new building now under construction.

Upper right—Present main building (on right in the sketch), showing portion of beautiful grounds.

Centre—Nurses' residence (on extreme left in the sketch).

This particular hospital is often criticized for hesitating to admit cases which would appear to be of long duration before it has been proven that prolonged institutional treatment is necessary. Many patients admitted have recovered unexpectedly in a short time, yet having admitted them it was often exceedingly difficult for us to obtain discharge; an example would be certain cardiac decompensation cases. Thus we become loaded with patients who do not need our facilities and so cannot admit others who should be here. Our former Minister of Health, Dr. R. P. Vivian, has recently stated, "If the chronically-ill patient is to be discharged from active treatment after sixty days, some other type of care must be provided". The limitation of sixty days' treatment in an acute hospital would put an increased load on the chronic hospital, and would emphasize the need for some arrangement to be made for the care of those ready to *leave* it. This provision must *first* be made, that space may be available for all sick people in need of hospital care of any kind.

Chronic Care not Cheap

To provide the chronically-ill with adequate care costs money. If hospitals for chronic patients are to give proper service to the chronically-ill, they must be staffed just as conscientiously as a hospital for acute diseases. Hospital buildings and trained personnel are expensive to provide, no matter what type of patient occupies the bed. It is true that the hospital for chronic diseases does not need many things needed in a general hospital, but it is also true that the active hospital does not need, or customarily have, many things needed in a hospital for the chronically-ill.

Moreover, the active hospital has a much greater chance of recovering its expenses for extra items than a hospital for chronic diseases, because the latter can seldom charge for "ex-

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Essentials in Organizing

The Medical Staff

Edmund Dubé, M.D.,
Medical Director,
Hôpital Ste. Justine, Montreal.

IF I were asked to organize the medical personnel of a new hospital, there are certain things I would like to accomplish.

Medical Director

The first principle for my guidance would be the choice of an experienced medical director, who would take an active part in the treatment of patients according to his chosen specialty. (May I state that I am using the term *medical director* with the understanding that it should not be confused with our interpretation of the term *superintendent* as the latter office may or may not be filled by a physician and the duties involved are often those of a manager). Direct contact with the problems which other members of the staff have to face is essential for the mutual understanding of both; such an appointment facilitates contact with the governing board, the members of which do not always appreciate the viewpoint of the doctors. The medical director should have, also, adequate knowledge of hospital administration in order to explain and interpret conditions and procedures to the medical staff. He should have a specified amount of leeway in making decisions. If conscientious and competent, he will certainly not make any major decisions which are not in accord with the policies of the governing board and medical staff or would not likely meet with their approval.

Heads of Services

One would then proceed to the choice of competent heads of departments, choosing the best men available and delegating to them full responsibility for the conduct of their services. They would be allowed, after consultation with the proper people, to recommend their assistants as it must not be forgotten that since these doctors must perform their work together there must necessarily be full sympathy and compatability among them.

Heads of departments and their assistants should not be required to provide unbroken service. At certain periods of the year, which may be every three or four months, they should be relieved of routine duty on the wards, although they should be held responsible for the work of their substitutes. This would permit a certain amount of time for the directing of research, would be encouraging to others attached to the staff and would do away with that "falling into a rut" which we so often observe.

The Staff as a Whole

A medical staff and its executive would then be formed to direct the problems of its members. The staff, or board* should number all the medical personnel and would be responsible for all medical affairs, including staff discussions of clinical cases and autopsy reports, etc. The medical staff should not neglect such timely topics as community health measures and social welfare.

The executive, composed of not more than five or six representatives, chosen from among the heads of departments and including the medical director, should be responsible for the discussion of all medical questions between meetings, such as general medical administrative policies and direct recommendations to the governing board.

The medical staff should be large enough to limit the number of public beds to each member. It is a mistake in my opinion to ask a doctor to take direct care of more than 12

Dr. Dubé is Dean of the Medical Faculty, University of Montreal. Address, Montreal Regional Conference of the American College of Surgeons, March, 1946.

** The medical staff is sometimes described as the "medical board" and in some hospitals the staff executive is given that name; in others, the Medical Board is a selected committee of senior members which is advisory to the Board of Trustees. Edit.*

Canada Savings Bond Campaign

- **There is no "high pressure" sales campaign this time. There will be no door to door canvassing or ballyhoo.**
- **There is no fixed quota objective.**
- **The Canada Savings Bond is planned to provide you with a safe and convenient means of investment.**
- **The amount of your investment is for your own determination.**
- **HAS YOUR HOSPITAL ADOPTED THE NEW PAY-ROLL SAVINGS PLAN?**

to 15 beds as it is impossible to give proper attention to more.

A general hospital is often called upon to receive special cases which cannot be transferred to special institutions due to circumstances over which there is no control. It is essential, therefore, that a consultant staff of competent physicians and surgeons be appointed to give advice and undertake any special treatment which may be required.

Interns and Residents

I would insist upon the choice of a competent resident who would have the necessary authority over the intern staff and would be required to have their full confidence. The choice of interns is most important for frequently they form the foundation for the future medical staff. A program of rotating services and of review in the basic sciences, most of which would be undertaken in university laboratories under proper guidance, should be insisted upon; moreover those interns who discharge their duties to the satisfaction of the authorities should be given some assurance that they may contemplate a future assignment to the staff. The hospital medical library should be open to the interns.

Finally, I would insist that the medical staff hold open meetings at intervals and invite the medical profession at large to attend, taking care to present those cases of most interest to the medical practitioners invited and reserving special cases for special meetings. I would also consider essential an annual publication containing articles of general interest by medical staff members. This, I believe, is most beneficial for the hospital, the staff and all those who are interested in medical subjects.

Small Hospital Plans

of Saskatchewan Government

Permit FLEXIBILITY in Size

IN the August issue of *The Canadian Hospital,* (page 31), we reproduced the ground floor plan of a 15-bed rural hospital and health centre recommended by the Health Services Planning Commission of the Saskatchewan Department of Public Health.

In this issue we reproduce the ground floor and basement plans of the 12-bed and 20-bed layouts approved by the Commission. Basically these layouts are all similar, the wing being extended to provide more beds as needed. The proposed 10-bed layout is like that for 12-beds except that the two single rooms to the right are omitted and, in the basement, the fuel room is swung around outside of the boiler room.

This arrangement permits the enlargement of the hospital at any time up to 20 beds in size. Beds are segregated in one wing away from the administrative, operating and health centre services. The ten and twelve-bed hospitals have all beds in single or double rooms. In the fifteen and twenty-bed layouts three-bed rooms are included.

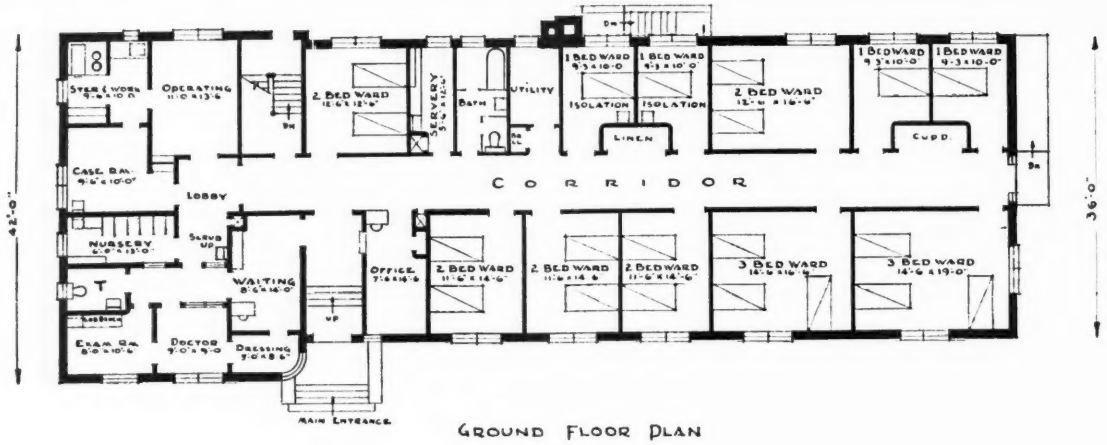
These plans were prepared by Messrs. Portnall and Stock of Regina who may be consulted by committees wishing further details respecting specifications. Construction has already commenced on this type of building at Watson and Maryfield. Building is anticipated in the near future at Bienfait, Kipling, Theodore and Eastend.

An estimate of present day costs (in Saskatchewan) is given on the next page.

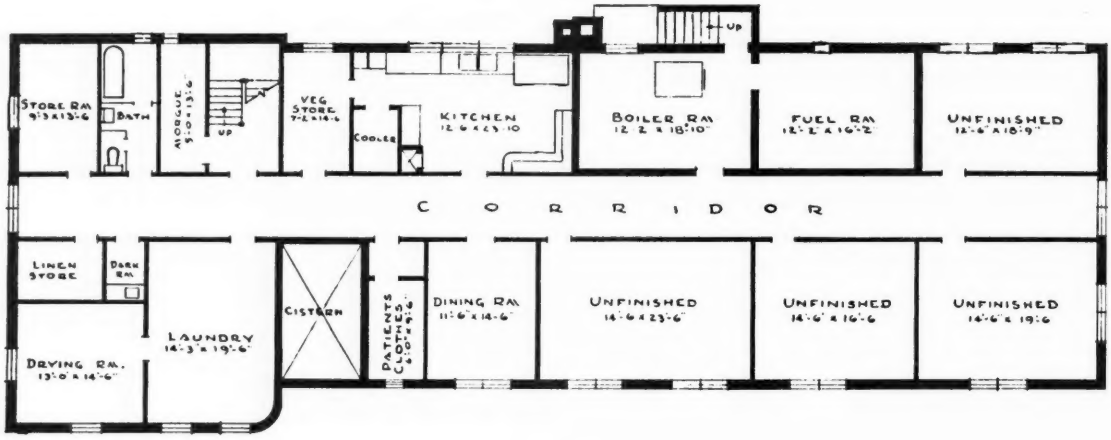
Rural Health Centre and Hospital

This perspective is of a 15-bed unit. The smaller or larger units would differ only in the lentgh of the wing to the right.

Proposed 20-Bed Unit



GROUND FLOOR PLAN



BASEMENT PLAN

This differs from the 15-bed unit only in the addition of the rooms on either side of the corridor to the extreme right. See August issue, page 31.

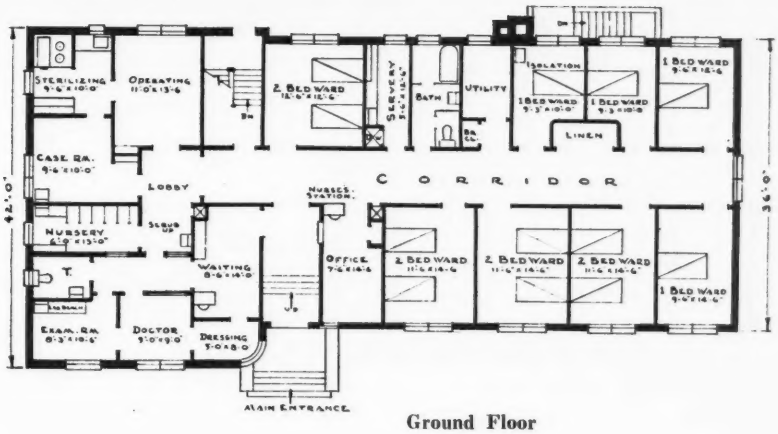
Costs:

A broad estimate of the likely building costs in Saskatchewan at the present time has been given. This would be for frame construction with either stucco or brick veneer finish, insulated walls and ceiling, hot-water heating, plastered walls and linoleum on the floors. Land and equipment are not included. The estimate does include the septic tank, automatic stoker and 2-pipe forced circulation hot-water heating system. Costs may be much higher in other provinces.

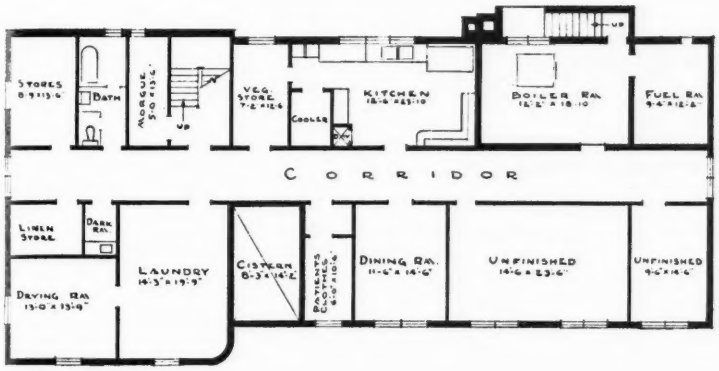
					Added Cost for Excavation
10-Bed	stucco	$49,147.65	brick veneer	$50,326.45	$497.40
12-Bed	stucco	$50,983.90	brick veneer	$52,206.20	$532.20
15-Bed	stucco	$52,537.30	brick veneer	$53,864.00	$556.20
20-Bed	stucco	$56,998.10	brick veneer	$59,437.60	$607.80

A Twelve Bed Unit

The clinical services wing on the left is similar to that of the 20-bed unit. For a 10-bed unit, the end rooms on the right would be omitted, the fuel room placed outside of the boiler room and the stairs placed at right angles.



Ground Floor



Basement Plan

New Health Appointments in Saskatchewan

Appointment of Dr. Leonard S. Rosenfeld, United States public health specialist, to the post of vice-chairman of the Health Services Planning Commission has been announced by Premier T. C. Douglas of Saskatchewan. Dr. Rosenfeld comes to Saskatchewan following nearly four years' service in guiding a re-organization of the health services of Nicaragua.

As assistant to Dr. F. D. Mott, recently-appointed chairman of the Commission, Dr. Rosenfeld will be particularly concerned with the introduction of the provincial hospitalization plan and with the integration of public health and medical care services within health regions.

Dr. C. J. Kirk, former assistant deputy health minister, has been appointed director of hospital planning and administration in the Commission in a move designed to centralize all matters relating to hospital facilities in the Commission and to coordinate them with the provincial hospital services plan which will be administered by the Commission.

C. C. Gibson, formerly director of hospital administration, has been appointed assistant director of hospital planning and administration in the Commission, and G. C. Darby, formerly administrative director of the physical fitness division, has been appointed executive assistant to Dr. C. F. W. Hames, deputy minister of health. No successor to Mr. Darby in the physical fitness division has been announced.

"This reorganization in the health department will promote greater efficiency in the handling of hospital matters, and will mean a closer coordination between medical and hospital administration within the department," said Mr. Douglas.

Father Schwitalla Convalescing

The many friends of the Reverend Alphonse M. Schwitalla, S.J., President of the Catholic Hospital Association of the United States and Canada, will be pleased to note that he has made a satisfactory convalescence this summer following a coronary occlusion. Unfortunately his illness made it impossible for him to attend the annual convention this summer of the Association of which he has been so long the able and indefatigable president. His many friends wish for him a complete recovery from his illness.

Buildings from the northwest as seen in September. To the extreme right is Block "A", the outpatient building; the large section in the centre is for administration and patients; Block "C" on the left houses the dietary department, recreation rooms, etc.; and the neurological building, Block "D", is hidden by "C". There is one straight corridor running through all five main buildings which is nearly one half mile long—2276 feet to be exact.

Neurological Unit Opened at Sunnybrook

ONE wing of the new Veterans Affairs hospital in Toronto, "Sunnybrook", is now complete and patients have been moved in. Known as "D" Block, this wing contains 165 beds and will house neurological patients.

When all of the wings have been completed, Sunnybrook will accommodate 1,450 beds with the most modern equipment available to medical science. The D.V.A. owns 400 acres of wooded land, surrounding the hospital and sloping to a stream. This will become a park which veterans may enjoy during convalescence.

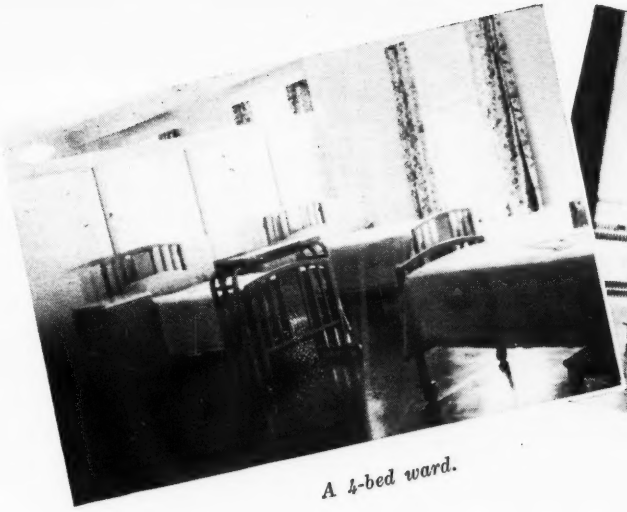
Block "A", now in the structural steel stage, will be for outpatients with a capacity of 10,000 per month. Block "B", nearly finished, will be the administration building in part.

Block "C", which it is hoped will be completed by the end of this year, contains the main dining rooms, with unusually large and well equipped kitchen facilities. Here it will be possible to serve 285 patients as well as staff members at one sitting. There is also a lounge suite, billiard room, canteen, a chapel and offices for padres. The auditorium, likewise in this wing, will seat 850 people. It will have five dressing rooms and appropriate stage props, together with screens for motion pictures. The walls will be covered with tapestry over acoustic tile. A system has been devised whereby the chairs can be folded and slipped under the stage, the whole process taking about twenty minutes, and the hall left clear for dancing. Finally, there is a well-equipped clinical theatre for teaching purposes, with ramps to accommodate wheel-chair patients.

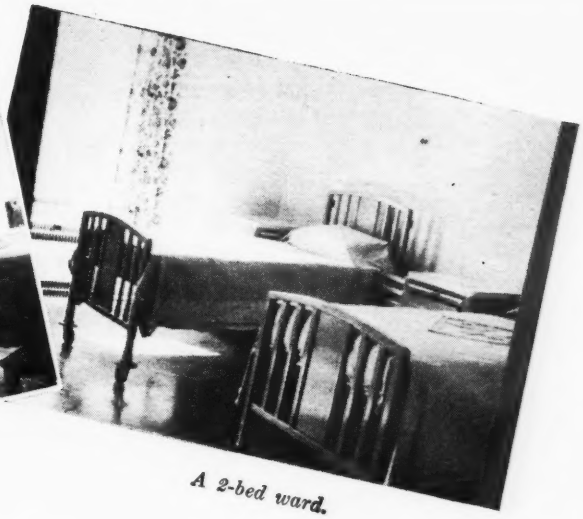
The splendid neurological building, Block "D" now in use, has been decorated and equipped with most careful thought for the comfort of the patients and convenience of employees. There has been free use of thermopane for the broad windows and these are so designed that they can be tilted over on a central rod and washed on both sides by an employee standing in the room. Screens move on smooth rollers and can be raised and lowered at will with practically no effort. Nurses' stations are light and airy, each having a bay window. Each station is also equipped with telautograph and a silent call system. A key cabinet is provided and there are wall safes for narcotics.

The encephalographic room has the most up-to-date scientific equipment and is lined with copper. A seclusion room has walls of polished wood rather than plaster, a minimum of furniture and true-lock, unbreakable screen on the window. In the adjoining washroom, pushbuttons replace tap handles. There is nothing in the ward by means of which a mentally ill patient could do harm and again nothing which would emphasize the fact that he is being confined.

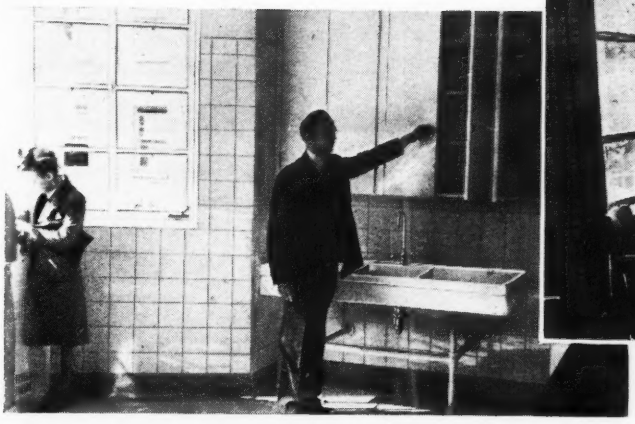
All rooms are bright and cheerful and the clever use of colour has contributed much to this effect. Predominating colours are ivory, mushroom and nile green—tones which are charming in combination and of high therapeutic value. Woodwork and furniture is in limed oak, including even the ashtray standards and waste baskets in the wards.

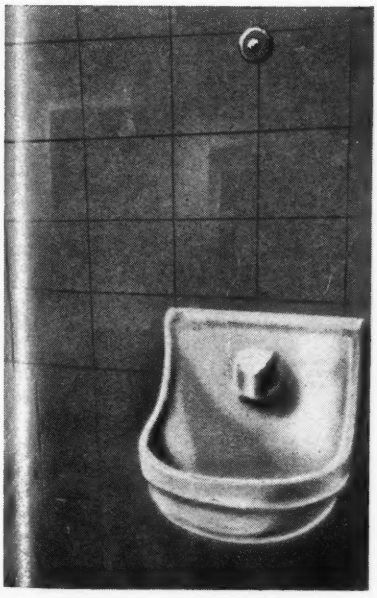


A 4-bed ward.



A 2-bed ward.



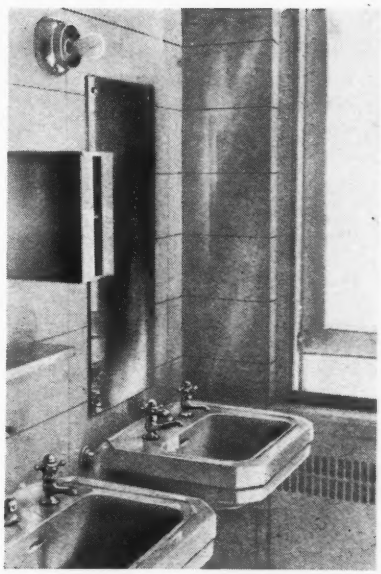


Middle left—The Administrator, Dr. K. E. Hollis, showing visitors one of the bright utility rooms.

Middle right—Each floor has a well-furnished all-year solarium.

Lower left—Push buttons replace tap-handles.

Lower right—Certain washbasins and mirrors are adjusted for wheelchair patients. Washroom doors are extra wide.



Gatch beds are of metal painted to imitate limed oak. Nile green counterpanes are decorated by a tufted diamond-shaped design enclosing the initials DVA. Each bed is supplied with a combination reading and writing stand adjustable to the patient's convenience and also a specially designed bedside cabinet complete with drawers, a towel rack and a stainless steel tray for soap and shaving kit.

At the end of the central corridor on each floor is a combination solarium and recreation room. These comfortable rooms reflect the general colour scheme of the building in the pastel tinted walls, homespun drapes and upholstered lounge chairs. Numerous low tables, again in limed oak, add to the comfort of the patients when reading or taking sun.

There is a home-like atmosphere throughout the building and this was enhanced, on the day it was opened to the public, by bouquets of flowers in every room. These were contributed by the Ontario Horticultural Society and we understand that it is the intention of the Society to keep the hospital supplied with fresh flowers.

Dr. K. E. Hollis is administrator of Sunnybrook and the architects are Messrs. Allward and Gouinlock.

Each floor has an attractive dining room for up-patients who are not well enough to go to the central dining hall.

MEDICAL RECORDS *are essential to* Sound Medical Practice

J. E. DeBELLE, M.D.,
General Superintendent, Children's Memorial Hospital, Montreal.

IN outlining the content and form of the medical record I feel that one can do no better than to quote from *Hospital Organization and Management* by Dr. M. T. MacEachern, who was largely responsible for the inauguration of medical records departments in hospitals:

> **"The medical record is a clear, concise, and accurate history of the patient's life and illness, written from the medical point of view. On the one hand, it sets forth factors which have contributed to lowered resistance and disease production; on the other, it calls attention to those which have produced increased resistance and details successful or unsuccessful efforts in combating disease in the past. The climax is reached in the story of the present illness as told by the patient and in the observations and treatment recorded by the attending physician, his colleagues and coadjutors. The contents of the record consist of a sociological section, one in which is noted the observations of the trained nurse and the detail of treatment administered, and finally a statement of the studies, observations, conclusions, and activities of the skilled physician."**

Address, Montreal Regional Conference of the American College of Surgeons, March, 1946.

What is the Value of the Medical Record?

This can be outlined under four headings:

1. Patient.
2. Hospital and attending staff.
3. Interns, medical students and student nurses.
4. Medical research.

The Patient

(a) Because of the complexity of laboratory procedures, coupled with the marked degree of specialization in modern medicine, accurate and up-to-date records must be maintained during investigation and treatment of patients in hospital. This is essential in order that intelligent conclusions may be drawn from the result of these special tests and examinations and the best possible treatment instituted.

(b) The medical record will be of value if, as and when, a patient requires future medical care, either at his home or in the hospital, for the continuation, or relapse of the same condition, or possibly to assist in the intelligent study of an entirely new disease.

In the event of future treatment the medical record of previous treatment may eliminate the necessity of repeating certain types of investigations and examinations, thus saving

time and expense. If, on the other hand the repetition of investigations or examinations is found to be necessary, a comparison with those carried out at an earlier date would be of great assistance both in treatment and in prognosis.

(c) A record of previous treatment may well be an important factor in deciding present or future treatments.

(d) Finally, the medical record may be of paramount importance to the patient in supporting his, or her, claim for compensation. Patients who fall into this category are service and ex-service personnel and those who come under workmen's compensation or other insurance or are injured in an accident.

Hospital and Attending Staff

A study of medical statistics and the individual medical records of patients with particular reference to investigative procedures, results of treatment, reasons for re-admission to hospital, mortality causes (either preventable or non-preventable), complications and infections will be of undoubted value both to the hospital and to the attending staff.

An intelligent use of this survey will enable the hospital and its attending staff to analyse the calibre of their work and to decide on various ways and means of eliminating undesirable conditions revealed from the above study. The medical record may be most useful to both the hospital and the attending staff in defence against a legal action for malpractice on the part of the patient.

Interns, Medical Students and Student Nurses

The medical record forms an exceedingly important part of their education, training them to be meticulous, concise, accurate and thorough in their case reporting. This should have a constant tendency to improve the quality of medical work. Interns, medical students and student nurses are forming their future habits during their day-to-day training in hospitals. It is our duty to see that the habits so formed are of the highest standard.

Medical Research

The accurate medical record has an important place in the field of medical research. It is frequently through a study of a series of cases that a new approach to a problem arises. New ideas on investigation and treatment are stimulated; they are proven to be either acceptable or useless and, as a consequence, are adopted or rejected by the profession. Let us remember that it is frequently through careful study of our failures that progress is made.

Medical Record Department

Since this department is one of the "babies" among hospital departments, it is unfortunate that such an important section is frequently accommodated in inadequate quarters and often in an inaccessible location. All of us realize that our records department must be provided with adequate quarters, that it should be located as close as possible to the out-patient department, and should be easy of access to the members of the intern and attending staffs. For obvious reasons, this is sometimes difficult to achieve.

As regards the various filing systems in use, it is generally considered that the *Unit System* offers greater advantages than other types. With this system the patient has one record regardless of the number of admissions to hospital. It is unfortunate that uniformity has not been achieved in our hospitals with regard to the type of system, the forms which make up the medical record, or in the choice of a disease nomenclature.

It is hoped, however, that a thorough study of these points by our registrars may result in standardization.*

Some Problems of the Medical Record Department

The difficulty of obtaining properly trained staff is still a problem with many of us. This should be gradually overcome since special training for medical record librarians is now available both in the United States and in Canada.

Probably the most urgent problem is the question of adequate and readily accessible storage space. This is a recurring heartache with many of us as our medical records departments are constantly pressing for more and more accommodation.

Another problem—and a burning one—is the disposal of "dead" records. Should they be photofilmed, or synopsized, and the originals then destroyed? Should they be kept? There is no doubt that they should be kept for a period of time, but if it is agreed that they should ultimately be destroyed, how long should they be kept? Certainly until no longer required for legal use.

Another problem common to all records departments is obtaining prompt completion of the medical record on discharge of a patient, both by the intern and by the attending staff. The importance of prompt attention to all paper work cannot be over-emphasized. Observations, impressions and conclusions should be recorded in black and white while all details are fresh in our minds and not days or weeks later. The finer details may well be forgotten if we delay and thus the value of the record is materially lessened.

In conclusion, satisfactory results can best be obtained by:

first, providing our medical records department with sufficient accommodation, correctly located;

second, providing our medical records department with a sufficient number of adequately trained staff;

third, constantly striving to obtain careful compilation and prompt completion of each medical record.

Hospitals and Health Centres

It would seem practical to suggest that health centres be constructed as a part of or adjacent to various strategically located hospitals in the most populous areas. These centres would be branch offices of the official governmental health department. In them could be located the branch administrative offices of the voluntary health agencies. The hospital would be used as in smaller communities. Its clinical, x-ray and laboratory facilities would not have to be duplicated by the health centre. Such close physical relationship between hospital and health agencies should promote a close integration of all activities, particularly of related programs.

—Commission on Hospital Care.

** The Canadian Hospital Council and the Canadian Medical Association have recommended the "Standard Nomenclature of Disease".*

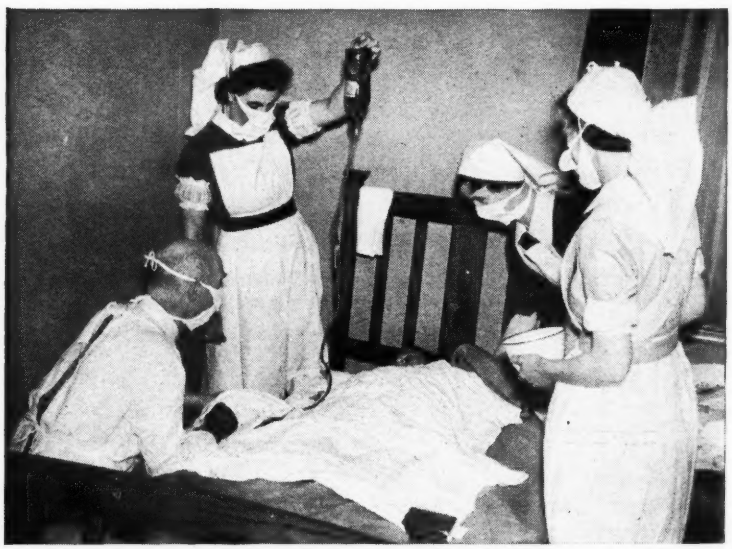
HULL'S

Maternity Flying Squad

From the District Midwives' Home in Hull (G.B.) a Maternity Flying Squad is available for emergency obstetrical work. An obstetrician and three midwives form the squad.

The Maternity Flying Squad leaving the Hull District Midwives' Home in the doctor's car.

The Flying Squad in action in the home of a patient. A plasma transfusion is being given for obstetric shock. Although full equipment is taken, many ingenious arrangements utilizing home facilities have been developed.



On the RELATIONSHIP of

Research and Pharmacy

The Past and the Future

IT is the function of the universities to look both backward into the past and forward into the future. On the one hand they store and study the accumulated experience of mankind and it is true that they run some risk of becoming fossilized and sterile in the process: but the best and most vigorous of them, at least, also peer forward along the trend-lines and strive to chart a course for humanity. The ideal university, then, is a modern Noah, remembering, at times a little wistfully, the days when "there were giants in the earth", yet full of plans and hopes for a new world. Like Noah, too, the university is apt to suffer from cramped quarters; and may have some rather odd specimens in the ship's company.

When I look backward to my own boyhood, not so very remote, it seems to me that the pharmacopoeia has changed more since then than it had in all its history up to that time. How few drugs we had then that possessed any really specific and dependable action! And of those that might so qualify, how few were recent discoveries! The vitamins and hormones were hardly known, the sulfonamides and antibiotics undreamed of. Quinine and morphine were but refinements of the long-known Peruvian bark and laudanum; most of our alarming battery of cathartics was inherited from previous generations—and very tough-fibred generations they must have been! We did have a few good antiseptics, some volatile anaesthetics, and the salicylates; but chemotherapy, even for protozoal infections, was in its infancy; and that legendary dog that accidentally broke

By DAVID L. THOMSON, M.A., Ph.D., F.R.S.C.,
McGill University, Montreal.

and licked up the first bottle of sulfonal was still pointing, almost in vain, at the tussocks from which we have since flushed the covey of barbiturates and other sedatives. All in all, it would hardly be an exaggeration to say that the pharmacopoeia of the beginning of this century had less in common with the one we know today than it had with that of the middle ages. We had indeed got rid of the witches' brews, the Indian snake-oil and the three hairs from a bigamist's left ear; but we were still freely prescribing drugs of dubious efficacy and unknown mode of action, and there was an uncomfortably large measure of truth in the old jibe that "Medicine is the art of amusing the patient while nature effects the cure".

In the extraordinary development that has since taken place, the pharmaceutical industry of this continent has played a notable part. It did so by whole-heartedly accepting the idea of progress, and by aligning itself with the most progressive elements in clinical and scientific medicine.

Against this background, let us try to interpret the flickering shadows cast by the future. In these days, perhaps we should ask first whether there is going to be a future. A distinguished physicist assured me that it was nonsense to suppose that atomic warfare could destroy the world; but, before I had time to become unduly elated, he added that it might easily destroy all the living creatures.

We may recall that the early brilliant successes of the sulfonamides, and even of penicillin, have been somewhat offset by the rapid appearance of strains of micro-organisms resistant to these agents. Not only are there many bacterial species which never were susceptible, but there are many which reeled back at the first shock but have since rallied and returned re-amoured to the attack. I spoke of this, not so long ago, to a physician I met in the jungles of British Guiana, and he derived some cynical amusement from the remark that this development of resistance was most noticeable in the gonococcus. He felt this to be an unconscious but illuminating comment upon the civilization he had gone so far to escape. Be this as it may, it is clear that the pharmaceutical industry cannot afford to lose sight of the phenomenon of acquired resistance. Just as bigger guns and

(Concluded on page 106)

Dr. Thomson is Professor of Bio-Chemistry and Dean of the Faculty of Graduate Studies and Research at McGill University.

Presented at the annual banquet, American Pharmaceutical Manufacturers' Association Convention, Chateau Lake Louise, Alberta, June 11, 1946.

Pasteur's Spirit Lives *in Work of* Institute

Professor Magrou studying the fertilization of orchids. Research in a wide range of pure sciences and the application of these sciences goes on constantly.

Professor Jacques Trefouël,
Director of the Pasteur Institute, Member of the Academy of Medicine.

IN September, 1895, Pasteur died and the world mourned. Through his research on moulds, on the diseases of silkworms, on coal, Pasteur had revived dying industries, helped thousands of farmers, sown wealth or halted devastation over whole provinces, given generously to others of the treasures of his genius. And when the course of his work led him to turn his attention to human suffering, he devoted all his efforts to relieving it.

The lasting quality of Pasteur's work was assured by its very value and by the fact that the master left behind him a doctrine, a working-technique, students inspired by his spirit and a research institute.

When the results of anti-rabic vaccination were announced, patients came from all parts of the world, and the quarters that Pasteur occupied at the Ecole Normale in 1886 became insufficient. An international public subscription fund was started by the Academy of Science to provide Pasteur with a micro-biological institute where he could develop his methods and train young scientists. The sum realized, 2,500,000 francs, made it possible to acquire, on Dutot Street, a piece of property on which was built the Pasteur Institute.

After the famous report by Dr. Roux on the serotherapy of diphtheria, requests for anti-diphtheria serum came in from all over the world. The quarters of the Pasteur Institute were not large enough to accommodate any new departments, so the newspaper *Figaro* started a subscription fund which netted a million francs. This sum was sufficient to fit up the property at Garches which had been placed at Pasteur's disposal by the Government when he was working on rabies and to install stables there to house the horses from which the serum was obtained.

Later, other donations made it possible to acquire another large property on which were built an Institute for the chemistry laboratories

Seeding cultures with microbes in the preparation of vaccine. Sera, anatoxins and biological products are supplied to hospitals, the medical profession and veterinarians.

and a hospital where Pasteur's methods were applied to therapeutics.

Noteworthy Achievements

What results are recorded for the 57 years which have passed since the inauguration of the Pasteur Institute?

Before Pasteur, mortality due to rabies was as high as 47 per cent (80 per cent for persons bitten in the face). Of 55,000 cases treated during the first 50 years since the institution of the treatment, only 155 deaths have been recorded. During the last 20 years there has not been a single case of death from rabies in Paris. Pasteur's vaccination method is still used at the present time. A quantity of anti-rabic vaccine was prepared at the Institute on the request of the American Army for its own needs.

Today the research laboratories are working in the same spirit in which Pasteur conceived them. Some are working on microbic toxins and their action on the organism; anti-toxins and their curative power. Others have penetrated the secret of cellular and humeral reactions which constitute immunity; have invented methods of diagnosis based on certain properties of the blood and the humours; discovered sera and vaccines; have shown that if certain microbes caused epizootic diseases, others were indispensable to life, such as those which fix the nitrogen of the air in the soil and thus make vegetation possible.

Courses to Resume

The training centre was voluntarily reduced to a minimum during the occupation years so as to prevent any attempt by the enemy to intrude. In spite of the difficulties inherent in the present situation, the principal course in bacteriology will resume this year, for it is on the training of research workers that the whole life of the Pasteur Institute depends.

Pasteur has not only left us a scientific heritage of the highest order which is in itself an example for scientists of magnificent concepts perfectly carried out; he has also left us a *technique*. At the Pasteur Institute it is passed from generation to generation of workers, more by oral teaching and practice than by the written word.

Group Research

However, those who are working on bacteriology at present bring to it a somewhat different approach from that of their predecessors. The day of solitary labours is past and in future scientists will work together in groups, each contributing his special knowledge to the common project.

The problems which remain to be solved are so complex that extensive knowledge of chemistry, physiology and physics must be required of those who intend to go in for bacteriology; inversely, some idea of that science is indispensable to chemists and physicists working in liaison with bacteriologists. "All the scientists gain by lending each other mutual support", Pasteur once said.

To cite only a few examples, measuring the corpuscular properties of the ultraviruses or bacteriophagi necessitates intensive work in physics and the construction of apparatus based on entirely new principles. There are at present three indirect measuring methods: ultra-filtration, ultra-centrifugation and radio sensitivity. These very different methods give comparable results which check with astonishing precision. The electron microscope makes it possible to

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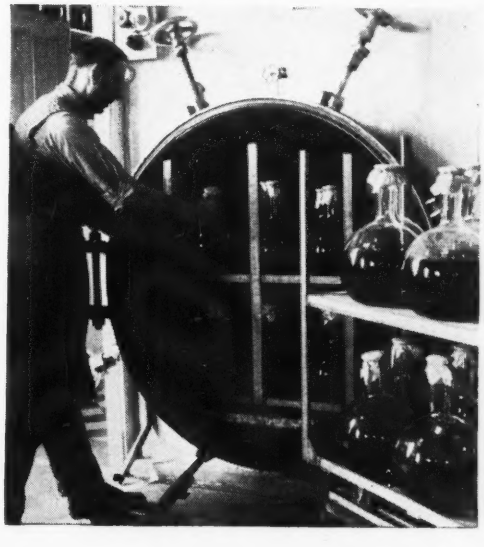


***Above:** Extracting marrow in the preparation of anti-rabic vaccine.*

***Right:** Sterilization of cultures. Some 20,000 litres of bouillon are prepared every week for the making of vaccines. Training is given to many bacteriologists and other research workers.*

Obiter Dicta

The Breakdown of Democracy

NEARLY one-third of the last thirty-odd years have been spent in bloody and costly defence of the principle of democracy and personal freedom. In that defence many thousands of our finest youth have given their lives. We wonder at times if that has been wasted effort.

Today the basic principle of a workable society—the maintenance of law and order by the democratically-elected government of the country—is being openly flouted by men whose actions are working inestimable direct and indirect hardship on the great majority of the people. Not only have the steel-strikers (and others before them) defied the government, but the government is doing woefully little to enforce its own laws or to safeguard the future of our strangled and fast-dying export trade.

Illegal strikes are bad enough, but when, as in the case of the Ford strike some months ago, the cars of law-abiding private citizens are forcibly taken from them by strikers (we cannot see much if any difference between that and deliberate theft), or violence is used to prevent workers from earning an honest dollar as at Cornwall earlier in the year, or, more recently, at Hamilton, the situation demands action. The picketing laws are utterly ignored. In the words of *Saturday Night*, "This is an absolutely impossible situation, which means the complete breakdown of all law and order". In other climes and at many periods in history, victims of this lawlessness have had to set up private protection, frequently developing private armies prepared to meet force with force. We have lost much freedom in recent years; no longer has a willing breadwinner, trying to support a family, the right to work when he wants to. Must we now raise companies of armed privateers to maintain production of essential materials?

It is very apparent that a basic weakness in democracy, as we have allowed it to develop, is a constantly recurring reluctance on the part of governments—irrespective of party—to take prompt, decisive action, no matter how logical that action would be, if there is any noticeable opposition to it. Within limits this is commendable, but we fear that all too often political expediency is the determining factor. Groups must not be antagonized. The unorganized majority must suffer, or be deprived of something, if a vociferous group, no matter how small, makes enough noise. In recent months it has looked very much as though democracy had become mob rule. It galls law-abiding citizens to see the affairs of this country being taken over by unqualified individuals, representing minority groups only, and, in all too many cases, officers or agents of organizations beyond our borders. What we need today is leadership, and more legislators big enough to risk their personal political futures in giving courageous leadership. We are pleased to note a definite stiffening of policy at Ottawa and at Queen's Park.

In deploring the inadequacy of action by the federal government (or a provincial government as the case may be) it would only be fair to note that government action everywhere would be greatly facilitated if it were not the universal practice of the opposition groups to seize every such opportunity to make political capital by criticizing whatever action the party in power does take. Our respect for our legislators would be greatly raised if, now and then, the left-benchers would stop playing politics and take a non-political, statesmanlike view of some of the issues being discussed. Nor does it help to know that, all too often, those sections of the press critical of the party in power, will try in every way to embarrass the government. It is this lack of a broad, national viewpoint, or sense of national responsibility, which makes it so easy for highly organized minorities to assume dictatorial powers and ultimately take unto themselves the reins of government. Democracy is letting itself commit suicide—and doing little about it.

Listing of Hospital Architects

IT is significant that the American Institute of Architects has declined to recognize the roster of architects specially qualified in hospital designing which was initiated by the American Hospital Association in 1944. This roster was set up in an endeavour to assist hospital committees in their selection of an architect, or a consulting architect, so that many of the atrocious blunders in hospital designing which have handicapped too many hospitals in the past could be reduced in future construction. Prominent architects representing the Institute assisted the A.H.A. in working out this list and now their work has been repudiated by their own body.

Much disappointment is being expressed over this action which prevents, or materially weakens, what could be a very sound development. Apparently the Institute takes the viewpoint that any registered architect is competent to design a hospital. Within certain limits there is some justification for this viewpoint, especially as the leading architectural magazines offer their readers the layouts and a few details of many of the better new hospitals. But there is much about hospital construction that cannot be obtained from books or even from visits. The architect must develop the viewpoint of the nurse, the doctor and the dietitian as well as that of the patient —and this takes time. The greatest handicap under which many hospitals must operate, year after year, is that they were designed by an architect then building his first hos-

pital. All too often he never gets an opportunity to utilize this costly experience in building a second one.

A factor in this decision by the Institute may have been the unfortunate publicity given to this list in the press. Naturally architects not listed would resent its publication. When this list was being compiled by the A.H.A., the Canadian Hospital Council discussed this movement with prominent members and officers of the Royal Architectural Institute of Canada and found that there was a general feeling that the architects here as a profession neither desired a special Canadian roster nor looked with favour upon Canadian architects making application for inclusion in the A.H.A. listing. As could be anticipated with most professional or trade groups, the large majority who would be excluded from special listings would be inclined to oppose them. As *The Modern Hospital* has stated, "If some of the members (of the A.I.A.) who voted against the A.H.A. (roster) had only been patients at one of those awful hospitals built by an architect who is a wizard on shoe stores or salmon canneries, the result might have been different."

Fortunately the professional qualifications of the registered architect are becoming more exacting, sources of information are more readily available and building committees are realizing more and more that an experienced hospital architect should be somewhere in the picture, if not in charge at least in a consulting capacity.

Set Salaries in Australia

WAGES and salaries for hospital employees in State of Victoria are standardized by Government regulation. This applies to all categories right through to the matron. Some of these items as issued by the Wages Board in 1944 may be of interest.

For instance nurses in training receive £2 per week the first year, £2 5s. the second year and £2 10s. thereafter. If the pupil nurse receives board and lodging, 20s. per week may be deducted. If, however, she or a certificated nurse lives out, the hospital must provide a further 10s. per week and one meal daily. One would like to know if university, business college and other students are paid also.

Another unusual feature is the scaling of the matrons according to the daily average number of occupied beds. For a hospital with less than 10 occupied beds the salary is £5 12s. 6d. per week; if there are 101-150 occupied beds the salary is £7 10s.; if over 300 beds, £9 10s. If there is a school for nurses the matron must get at least £6 2s. 6d., the salary for a 20-39 average occupancy. Deputy matrons are on a comparable scale, receiving £5 15s. for 101-150 occupied beds and £7 5s. if over 250 beds are occupied.

Certificated nurse dietitians in charge receive £6 per week during the first year, £6 5s. the second year, and thereafter £6 10s. The senior instructor has a similar scale. Staff nurses receive £3 15s. the first year, £4 the second and £4 5s. thereafter. Employees on call receive an additional 4s per week. Except for the matron and the x-ray sister-technician, time and a half is paid for overtime in excess of the normal time for a four weeks' period, or for a shorter period over 50 hours per week. Staff nurses and trainees get three weeks' holidays; all others get four weeks with pay. Sick leave is one day per month of service in the first year, then 14 days and 21 days after the fourth year.

In a ruling of the Industrial Appeals Court in March of this year further schedules are published. Waitresses receive 63s. weekly; typists 72s. 6d. to 77s. 6d. Laboratory assistants (female) 78s. and 121s. if male, but registered x-ray technicians 92s. 6d. to 102s. 6d. if female and 113s. 6d. to 138s. 6d. if male. (Laboratory technicians are not rated as well as here.) Orderlies get 118s. and dressers doing V.D. work 136s. First cooks receive 125s. 6d. if male and 77s. 6d. to 95s. if female. The housekeeper receives 82s. 6d. The Australian shilling is equivalent today to sixteen cents Canadian (£1=$3.24).

This minimum scale of wages has much to commend it, even though we might vary the amounts for different categories. But we question the inclusion of the matron. In executive positions the variation in ability becomes tremendous and some at a high salary are a better investment than others at half the price. Frequently, too, the matron of the small hospital has the harder job. One would prefer to see her salary graded on the basis of training, experience and rating of past performance.

How Costs Have Risen

OF the rising of hospital costs there would seem to be no end. Certainly there is no indication, either on a short-range or a long-range scale, that the cost curve has begun to flatten to a plateau. Writing on this subject in his new book, *The American Hospital*, Dr. E. H. L. Corwin cites the per patient per diem costs in a gynaecologic and obstetric hospital in New York City as an example:

Year	*Cost per Adult Patient Day*
1857	$ 1.00
1867	1.00
1877	1.40
1887	2.00
1897	3.20
1907	4.60
1917	5.10
1927	8.65
1937	9.15
1944	11.25

The rate of increase in the thirty-year period 1887-1917 was almost identical with that of the twenty-seven year period 1917-1944.

Canadian figures would show a parallel rise. Referring to costs at the Royal Jubilee Hospital in Victoria, Mr. G. H. Stevens, president of the Board, stated recently that costs there had risen 78 per cent over those of 1939. Payroll costs have gone up 98 per cent since 1939 and in 1946 have been 4.8 per cent over those of 1945. Yet municipal payments and government grants have either remained stationary or have shown increases which are far from adequate.

When Should a Patient be Told the TRUTH?

WHEN Pilate asked Jesus, "What is the truth?" He did not answer. After a doctor has completed a careful examination he will frequently be in possession of information about a patient that will indicate to him quite definitely that the patient is suffering from a serious disease which is in a probably or possibly curable condition if a certain course of treatmen or of surgery is carried out promptly. Should he then and there tell the patient "the truth, the whole truth and nothing but the truth" and then ask the patient to let him arrange for the treatment? Is it *possible* to convey the "truth" about a serious matter to a patient?

In any group of patients with identical surgical or medical conditions there will be a very wide variation in their mental states, physical states, social circumstances, and in the amount of information or misinformation concerning disease in their possession. Let us assume that a group of patients has gone to a man who is their final authority because they believe him to be an expert in the care of such cases. The doctor finds that the patients all have carcinoma of the breast, that if he operates on them there is essentially no danger of immediate death and that after operation known averages would lead him to believe that one half the group would survive five years without recurrence.

Now suppose the doctor bluntly starts his conversation with the statement, "This is a cancer" and follows up by outlining the assumptions as to chance of recovery. This statement will be given a very different interpretation by each of the ten different patients and none of them will interpret from it exactly what is going on in the doctor's mind. Many will interpret "cancer" as identical in meaning with "hopeless cancer". Perhaps eight of the patients might consent to proper operations but of these half might never forgive the doctor for his brutality. One of the remaining two might be among the number of people who believe erroneously that cancer is never cured and therefore decide to have no treatment. The other might be so upset mentally that she leaves the doctor and goes to a charlatan in whose hands all hope of cure will be lost.

On the other hand if the doctor avoids the word "cancer" and minimizes the seriousness of the situation, eight patients may consent. The one who recurs the earliest will blame the doctor by stating that the operation was not worth while, and that if she had known how serious the condition was she would not have consented. The other two refuse operation because they have not taken in the urgency of the situation and thereby lose their chance of cure.

It is seen then that blunt "truth" is not good and that avoidance of truth may be as bad. How then should the doctor proceed with such an interview?

Conducting the Interview

Quoting L. J. Henderson: "The idea that the truth, the whole truth and nothing but the truth can be conveyed to the patient is an example of false abstraction, of that fallacy called by Whitehead 'The fallacy of misplaced concreteness'. It results from neglecting factors that cannot be excluded from the concrete situation and that have an effect that cannot be neglected . . . You must not suppose that I am recommending, for this reason, that you should always lie to your patients . . . However, since telling the truth is impossible, there can be no sharp distinction between what is true and what is false. But surely that does not relieve the physician of his moral responsibility. On the contrary the difficulties that arise from the immense complexity of the phenomena do not diminish, but rather increase, the moral responsibility of the physician. . . .

"Far older than the precept, 'the truth, the whole truth and nothing but the truth' is another that originates within our profession, that has always been the guide of the best physicians and, if I may venture a prophecy, will always remain so: So far as possible, 'Do no harm'. You can do harm by the process that is quaintly called telling the truth. You can do harm by lying. In your relations with your patients you will inevitably do much harm, and this will be by no means confined to your strictly medical blunders. It will also arise from what you say and what you fail to say. But try to do as little harm as possible, not only in treatment with drugs, or with the knife, but also in treatment with words, with the expression of your sentiments and emotions. Try at all times to act upon the patient so as to modify his sentiments to his own advantage, and remember that, to this end, nothing is more effective than arousing in him the belief that you are concerned wholeheartedly and exclusively for his welfare."

At the start of an interview the doctor should avoid the words "carcinoma" or "cancer". He should use cyst, nodule, tumour, lesion or some other loosely descriptive word which has not so many frightening connotations. He should then suggest that operation is indicated and give some rough idea of the extent of the operation. If consent is given this is enough. But he should inform the most interested relative that there is only a 50 per cent chance of a successful outcome. If the patient resists the idea of operation the matter may be presented to the family. If the patient does not want her husband to be told anything, the doctor can at least state that the lesion is in imminent danger of becoming a

Condensed from an article by Charles C. Lund, M.D., of Boston, entitled "The Doctor, the Patient and the Truth" in the Annals of Internal Medicine, 24:6, 1946.

cancer and that a good chance of cure still remains if action is immediate.

If the patient asks directly, "Is this cancer?" the doctor is forced to answer "Yes", but can always go on to explain in the same sentence, "but it probably is not as serious as you fear because you have a good chance of cure."

After operation the first things many patients want to know are what was found, what was done and what is the expected result. What should the doctor tell the patient at this time? When the patient is still under the influence of opiates or sedatives, he must be told nothing. Later, however, at a more opportune time, the doctor must be frank. In spite of the frequent requests by relatives not to do so, the patient should almost always be told exactly what was found at operation and exactly what was done. Harsh words and bald facts should be tempered to a reasonable degree. If the outlook is probably but not surely favourable, this statement must be made so that the patient will cooperate properly in follow up examinations or treatments. If the outlook is thoroughly bad and the doctor is quite sure the patient will die shortly what should he do? Of course, tell the responsible relative at once. His procedure with regard to the patient must vary with different patients.

Almost always it does more good than harm to tell the patient who is in a hopeless situation the truth about his prospects. This must always be done gently, and perhaps indirectly. A question as to whether the patient would like to see his clergyman or to make his will would mean much to some patients. Following such a suggestion the patient will often ask a direct question and should be given a direct answer.

In conclusion, the doctor is bound in his duty to his patient to do whatever is best for his patient and to avoid doing him harm. Sometimes, for the patient's own good, it is not possible to tell him the "whole truth". However, there are frequent circumstances in which friends and relatives want the "whole truth", (unpleasant) kept from the patient when it is much better for the patient if the doctor is quite frank.

Charles Camsell Hospital, Edmonton, Main Building

Edmonton Hospital for Indians Named After Dr. Camsell

The former military hospital at Edmonton, which was turned over to the Department of National Health and Welfare early in the summer to be used as a sanatorium for Indians and known as the Indian Health Service Hospital, has been renamed in honour of Dr. Charles Camsell. This change took place when the hospital was officially opened by the Rt. Honourable Viscount Alexander, Governor General of Canada, in August.

Dr. Charles H. Camsell, C.M.G.

Deputy Minister of Mines and Resources for sixteen years previous to his retirement in July, Dr. Camsell was actively concerned in the administration of Indian Affairs, a branch which has since been transferred to the Department of National Health and Welfare.

However, his interest in the native races did not begin with his appointment to Ottawa. Charles Camsell is a native of the Northwest Territories. He was born at Fort Laird where his father was a Hudson's Bay Factor and he came out only for the purpose of university training in Manitoba, followed by post graduate study in geology at Queen's and Harvard. He returned to the northwest in 1894 and from then until he went to Ottawa in 1920 he lived and worked among the Indians and Eskimos. There are but few who have trodden so far and wide through northern Canada. He travelled in various capacities, as lumberman, boatman, guide, mailman, teacher, explorer and geologist. He is equally at home in a scientific laboratory, chatting with an Indian chief in his native tongue, discussing fur catches with a trapper in some remote northern cabin or on a golf course. Dr. Camsell is now Commissioner for the Northwest Territories.

With the Hospitals in Britain

By "LONDONER"

C. E. A. Bedwell

Dear Mr. Editor:

In my last letter I gave some account of the surveys which have been made under the auspices of the Ministry of Health of the hospital services of the country. These have been supplemented by a survey of the mental health services, which was undertaken with official encouragement, though not with quite the same direct authority as those relating to the hospitals. This report is the work of Dr. C. P. Blacker and has been published in the series of Oxford Medical Publications with the title *Neurosis and the Mental Health Services.* Its immediate importance is derived from the fact that the national health service bill enables the mental health services to be administered in conjunction with the other health services. This is not just a matter of organization but one of practical value to the patients, as experience has shown that the prejudice against psychiatric treatment has been markedly reduced since it became available under the auspices of general hospitals. It may well be that this section of the measure will contribute more to the real health of the nation than others which have been occupying public attention. It must be frankly admitted that the mental is the Cinderella of the health services of the country, and Mr. Aneurin Bevan is fortunate to have been entrusted with the role of Prince to come to her rescue.

Dr. Blacker had the assistance of a team of surveyors representing the Emergency Medical Service, the Board of Control, which is the body responsible for the mental hospitals, and the Army. Their reports have the advantage of being co-ordinated by one mind, which was lacking in the general hospital surveys. The result is that the report presents a basis for action so soon as the new Bill has been passed into law.

As a first step to be taken towards the removal of the existing prejudice, Dr. Blacker advocates that the priority be given to the psychiatric treatment of children and juveniles. The first sphere in which he would apply it is in dealing with juvenile

A New Approach to Mental Care

delinquency. This is already receiving attention from an advisory council which advises the Home Office as the responsible Government department. The delinquents are often recruited from the dull and backward children, who provide an opportunity for collaboration between the education authorities and the psychiatric service. That leads back to the environmental conditions of early childhood and the contribution of the adults with responsibility for the children—who may provide another group of patients. In order to deal with children and with the accessory services which they demand, larger and more modernized premises are needed than for adults. But, having been provided for the children, there is no reason why they should not be used at other times by adults and so render the service more attractive to them also. The child psychiatric clinic thus established under the auspices of the health authority would be available for the children referred to it from the child guidance clinic established by the education authority.

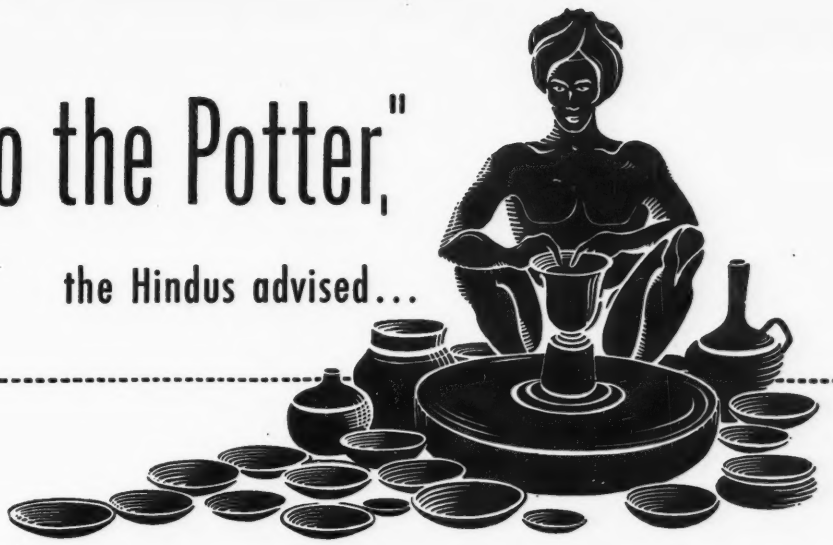
The attractiveness of this line of approach is that the rising generation may develop healthy habits of mind and so diminish the number of those who show unbalanced tendencies in later years. At the same time the idea of the mind receiving treatment in the same way as the body will become generally accepted in substitution of the popular association of mental ill-health with lunacy and incarceration under some form of certification in an asylum. Some of the modern mental hospitals embody an entirely different conception, but there is still too much of a less enlightened view, especially in those buildings which were erected by a previous generation.

Dr. Blacker surveys the whole question of the extent and nature of the accommodation required for mental patients. In addition his recommendations discuss fully the qualifications necessary for the medical and nursing staffs and the training appropriate to equip them for their important work. This subject has already received attention in special reports of the Royal College of Physicians and in relation to medical teaching as a whole in the interdepartmental report on medical schools known as the Goodenough Committee. Thus it is anticipated that psychiatric teaching will form an integral part of the work of the teaching hospitals of London and the provincial universities.

The developments envisaged by Dr. Blacker will touch life at many points, such as the contribution which may be made in order to secure full employment for that body of men and women who tend to drift into the ranks of the unemployed and gradually deteriorate until they form the hard core of the unemployable. These are in a number of cases men in a condition of mental ill-health, and if the Ministry of Health can bring their services to aid the Ministry of Labour in making these men self-respecting and self-supporting citizens, a contribution of first class importance will have been made to the national welfare.

"Go to the Potter,"

the Hindus advised...



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**Ballingall, Sir George: Outlines of Military Surgery, Edinburgh, 4th ed., 1852, p. 358.*

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Statistical Data on Hospitals in Canada

THE review of organization and operation of the hospitals in Canada, published by the Dominion Bureau of Statistics at Ottawa, 1946, is actually the annual report of hospitals for the year 1944 and has just been released. It deals with public hospitals as defined under the various provincial hospital acts, private hospitals and Dominion hospitals. The purpose of the report is to present in as full detail as possible statistical data on hospitals, covering beds and facilities available, hospital personnel, movement of patients and of finances, in each of the provinces of Canada. Six of the 592 public hospitals known to be operating in this country did not provide reports to the D.B.S. and so are not included in any of the tables in the volume. The book has been prepared under the supervision of Mr. James C. Brady, Chief of the Institutional Branch, Dominion Bureau of Statistics.

The 586 hospitals for acute diseases which provided reports had a capacity of 51,913 beds and cribs and 7,419 bassinets for newborn. General public hospitals had 87.9 per cent of the total number of beds and cribs and 90.5 per cent of the bassinets.

Based on the total population of Canada, the number of beds and cribs per thousand of the general population by provinces was:

Prince Edward Island	2.9
Nova Scotia	4.1
New Brunswick	3.5
Quebec	4.1
Ontario	3.8
Manitoba	4.7
Saskatchewan	4.3
Alberta	5.9
British Columbia	5.5
Yukon and Northwest Territories	1.9
CANADA	4.3

Hospitals having a total capacity of less than 100 beds, cribs and bassinets numbered 433 or 73.9 per cent of the total while those having more than 100 beds numbered 153. The average capacity of all hospitals in Canada was 100.3 beds.

Personnel

One hundred and twenty-one public hospitals employed 377 full-time doctors, and 122 institutions employed 347 part-time doctors, a total of 724 doctors receiving salary. There were 826 interns employed in 98 hospitals.

The number of graduate nurses on hospital staffs was 8,923, an increase of 244 or 2.8 per cent over the preceding year. There were 160 hospitals which had approved schools of nursing, 52 of which had university affiliation. These schools had a total of 1,924 probationers and 9,816 student nurses, 3,684 of whom were graduated during the year. The total personnel of all reporting hospitals was 47,302, an increase of 2,938 or 6.6 per cent.

Facilities

There were 268 hospitals, one more than in 1943, which had organized medical staffs. There were 482 hospitals having x-ray facilities; 263 hospitals had clinical laboratories, while 128 had physiotherapy departments.

Fifty-seven hospitals supplied reports of their organized out-patient departments. Total number of patients was 275,728, and 1,425,872 treatments or visits were reported.

Movement of Patients

The 586 public hospitals which provided returns for the year 1944 had a complement of 49,991 beds and cribs, 72.9 per cent of which were occupied during the year. The percentages of occupancy by provinces were: Prince Edward Island, 77.9; Nova Scotia, 74.8; New Brunswick, 71.1; Quebec, 77.2; Ontario, 74.5; Manitoba, 71.7; Saskatchewan, 67.3; Alberta, 65.3; British Columbia, 70.7 and Northwest Territories and Yukon, 38.8 per cent. A notable feature of the bed group tables is that the percentage of bed occupancy increases directly as the bed capacity increases.

Admissions and Discharges

There were in residence in public hospitals at the beginning of the year 35,093 patients, which was an increase of 3.6 per cent over the previous year. The number of admissions for the year 1944 was 1,234,327, an increase of 5.9 per cent over 1943.

A total of 1,269,427 patients were under care in public hospitals for acute diseases during the year 1944. The increase over 1943 was 70,327 or 5.9 per cent.

Separations (discharges and deaths) during the year totalled 97.2 per cent.

The total patient days during the year was 14,975,802, giving an average stay of 11.8 days for all patients.

There were 168,311 births in public hospitals during the year, 61.6 per cent of all births in Canada.

Twenty-six hospitals provided returns concerning their tuberculosis units indicating a total capacity of 1,613 beds, 78.9 per cent of which were occupied during the year. Eleven hospitals reported movement of patients in contagious disease units. These had a total of 337 beds, 35.7 of which were occupied during the year.

Finances

Five hundred and sixty hospitals provided reports on revenue and expenditure. Total revenue of public hospitals for acute diseases amounted to $68,263,583 and total expenditures to $68,939,717, showing a net operating loss of $676,134.

Detailed figures show that salaries and wages made up the largest single item for maintenance; this amounted to $31,113,645 or 45.1 per cent of the total expenditures. Supplies was the next largest item, amounting to $24,015,344 or 34.8 per cent.

Of the $68,939,717 which was expended for maintenance, $3,785,637 was for out-patients and $65,154,080 for in-patients. This latter gives a cost per patient-day, for all hospitals reporting, of $4.25.

Hospitals for Incurables

There were 15 hospitals for incurables in Canada in 1944. These had a total capacity of 3,185 beds, while the bed complement or number available for use was 3,126. The percentage of beds occupied was 92.5 and the average stay during the year was 245.8 days.

The number of private hospitals reporting in 1944 was 267. Of the 3,821 beds and cribs 47.9 per cent were occupied during the year.

(Concluded on page 112)

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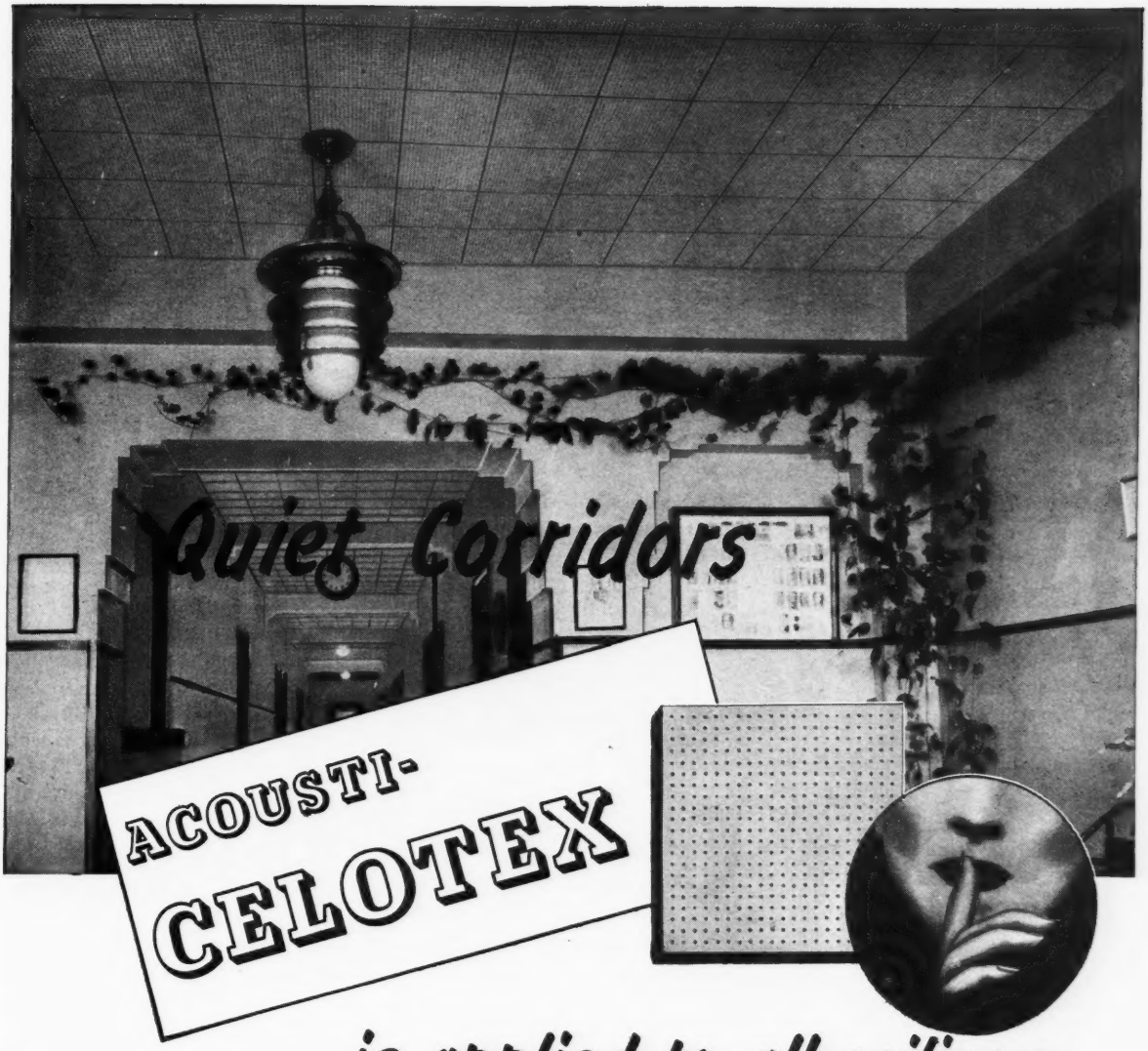

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Here and There

by "The Editor"

Is That True?

IN a recent issue of *The Saturday Evening Post* a writer notes that "Surgeon General Parran estimates that 40 per cent of our population live out of reach of hospital service". That is a lot of people—over fifty-two million Americans! We question this quotation for Surgeon General Parran, head of the U.S. Public Health Service, is a well-informed man.

A study of hospital facilities in the United States was made just before the War. At that time the Interdepartmental Committee on the National Health Program of the Federal Government proposed 500 new general hospitals to be built in counties without hospitals. Realizing the need for more hospitals in some areas but fearing the possibility of wasteful duplication in many areas, Dr. MacEachern and Dr. Bert W. Caldwell, then Secretary of the American Hospital Association, stated that "there was a reasonably good hospital within 30 miles of 98 per cent of the population". With present day roads and transportation facilities, this is not bad, especially as the percentage beyond a 15 or 20-mile radius would be very small indeed. These figures were confirmed by a survey made by the American Medical Association which found that there was a "registered" hospital (still better) within 30 miles of 98.8 per cent of the population.

In a study made in 1940, Dr. T. R. Ponton found that additional small hospitals were needed in 12 states only and just first aid stations in thirteen. He recommended enlargement of existing hospitals, a need greatly accentuated in the intervening period. In the U.S. Public Health Service study of "Health Service Areas" last year, Dr. Mountin, Mr. Pennell and Dr. Hoge recommended that "State plans preclude approval of any project for a hospital of less than 50 beds". Agreeing, however, that patients should not be required to travel more than 50 miles except for uncommon conditions, the authors suggested combining a limited number of beds for emergency and local needs with health centre facilities in certain rural areas. This is now being done in western Canada.

We fear that the quotation, or misquotation, attributed to Dr. Parran will give a quite erroneous impression of the really excellent hospital system in the United States (and Canada) to a wide circle of readers.

* * *

Inflation Plus Plus!

Some people must have lots of money. At least they spend it freely. The other day a friend saw a woman at the hair dresser's get a bill for two dollars, toss over a five-dollar bill and nonchalantly say, "Keep the change"! Perhaps that is why none-too- obsequious waiters and others with the upturned palm feel free to sniff at the conventional 10 per cent.

Now we hear of a Toronto woman who mailed a cheque for $28.00 to a local hospital in payment of her account. But her hospital account was for $25.00 only. The puzzled accountant telephoned the woman asking the reason for the extra $3.00.

"Well, of all the dumb things I do when I'm absent-minded," she exclaimed. "I couldn't find another three-cent stamp for the cheque, so I added $3.00 to pay for it."

* * *

Cat Nip

My first confinement case was in a little, two-room cabin in a lonely Kentucky valley. When I arrived I found my patient deep in labour pains, her bed surrounded by five or six neighbors and half a dozen of her own offspring. Self-consciously I removed by hat and coat and—trying to assume a bedside manner—popped the old bromide: "Well, what do you hope it will be—a boy or a girl?" Just then the patient was stricken with a severe pain. Between her clenched teeth she hissed: "I hope the damn thing's a wildcat and takes to the mountains."

—J. A. Carrier, M.D., in Medical Economics.

* * * *

New Kind of Hospital

The British Red Cross Society has made what is described as "an interesting small social experiment on new lines", by opening in Birmingham a hospital for women patients who, in the opinion of their doctors, are not sufficiently ill to require admission to a general hospital but who cannot be adequately nursed at home. This meets a need to which very little attention has hitherto been paid. There are many thousands of persons throughout the country who require attention which they cannot give to themselves, but which do not necessitate their occupying a hospital bed. In the case in question, the building is the King's Heath Vicarage, and it was opened by Lord Woolton. His Lordship said that whatever a Government might do in the direction of taking over hospitals, and providing money for them, there would still be abundant work for philanthropic enterprise. This is a very sensible remark, which should bring consolation to those who imagine that charity will disappear if the voluntary hospital system is destroyed. The new departure at Birmingham is a good indication of how philanthropy can find scope. The general medical practitioners of Birmingham are co-operating with the British Red Cross Society in running the hospital, and it is the intention of the Society to open other similar institutions when suitable buildings can be obtained.

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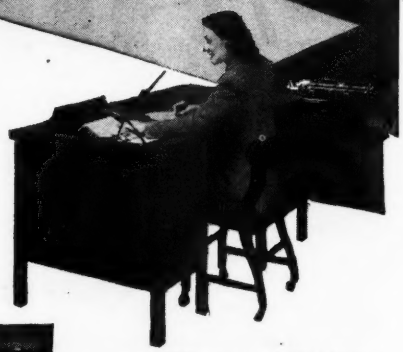

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Windsor Hospitals Surprised at Fire Chief's Criticism

HOSPITALS in general, and Windsor (Ont.), hospitals in particular, came in for severe criticism from Windsor Fire Chief D. F. Fields at the annual meting of the Dominion Association of Fire Chiefs in Timmins. He criticized severely officials responsible for emergency lighting units in hospitals and other public buildings.

"The tornado at Windsor (see *The Canadian Hospital*, July pp. 30-31) cut off the city's hydro-electric supply for 48 hours and during that period the only independent lighting units that would operate were the ones in Windsor's fire halls. Hospitals and other public buildings where the dead and wounded had to be carried had to operate with kerosene and gasoline lamps and candles," he said.

"It was the most disgraceful exhibition of neglect I have ever witnessed in my 50 years as a public servant. After the tornado I personally inspected many of these public buildings to find out why their gasoline generators had not been put into operation. At one large hospital I found a $5,000 unit covered with junk that had accumulated for two years previously. I venture to say that if you people at this banquet were to inspect the independent lighting equipment in your respective hospitals you would find the same disgraceful condition. If I am wrong, and I hope I am, your hospital will be one of the very few in Canada in which this shameful neglect is not in evidence."

That the situation was not ideal was stated in the July account of how the hospitals handled the situation when scores of injured survivors were rushed to their doors between six-thirty and eight o'clock in the evening. Apparently Grace Hospital was the only one possessing an emergency lighting system, a system covering delivery rooms, corridors, office and laboratory (including microscope). As this proved inadequate, the Fire Department was called and quickly set up its mobile lighting unit with flood lights in the operating rooms. The Metropolitan had a few emergency lights, emergency operating lights and flashlights. The Hotel Dieu had the additional disaster of the engine room filling with water because of the shutdown of the electrically-operated pumps. It depended upon flashlights, and gasoline and oil lamps for an hour or more until battery sets were obtained. A major problem in all was the shutdown of elevators and the difficulty of keeping up steam for the sterilizers and the cooking.

However, the patients did receive excellent care. Day staffs stayed on; neighbors donated torches and lanterns, the Mayor rushed over batteries and generators from Detroit. Sister Marie de la Ferre has praised highly the efforts of the Mayor and of the hospital's Chief Engineer. Although she was surprised at the criticism in the light of the satisfactory handling of the situation, she is "heartily in accord with our Fire Chief that emergency units should be available for our hospitals, not only for lighting but for power as well".

Mr. Horace Atkin, superintendent of the Metropolitan General Hospital, states: "Hospitals, like many organizations and institutions, are not always 100 per cent perfect. There are always many things that we would like to have that are not always available because of lack of funds and other conditions. The hospitals in Windsor were all adequately equipped with emergency lighting so that all patients could receive necessary aid. I am positive there was not a person injured or a life lost due to the lack of any emergency lighting. This is the most essential point.

"As far as electrical generators are concerned, we find that all of this equipment is sold in 60 cycle and would not service the equipment which is in use in this hospital.

"I fully realize that an elaborate electrical generator capable of running elevators, etc., would be a fine asset to any hospital. However, I do believe that the average small hospital hesitates to spend such a large sum for this equipment. We are not sure that the next emergency might even render the electrical wiring in the building useless for any kind of current."

As for the $5,000 unit covered by a two years' accumulation of "junk", the unit at Grace Hospital had a broken cylinder head which had not been repaired, chiefly due to the shortage of help. Unknown to the superintendent, "some orange boxes, etc.", had been left among the machinery. Since the tornado, however, the equipment has been fully repaired.

Even from a Fire Chief's angle it is strongly put to say (as quoted), "It was the most disgraceful exhibition of neglect I have ever witnessed in my 50 years as a public servant". For every hospital to be fully prepared for every emergency would probably cost so much that neither municipalities nor private patients would be willing to meet the additional costs. As in so many other situations, it is a matter of weighing costs against possible benefits, and in the eyes of many, hospital costs are already prohibitive.

Nevertheless, it is Chief Field's task to point out what would be ideal, irrespective of costs. He knows the importance of having good equipment and of having perfect organization for emergencies. His castigation may serve a useful purpose across Canada.

Coming Conventions

October 21-23—Ontario Hospital Association, Royal York Hotel, Toronto.

October 23-24—Ontario Conference, C.H.A., St. Michael's Hospital, Toronto.

October 28-November 2—Institute on Administration and Convention, Manitoba Hospital Association, Royal Alexandra Hotel, Winnipeg.

November 5-6—Saskatchewan Hospital Association, Saskatoon.

November 6-8—Associated Hospitals of Alberta, Palliser Hotel, Calgary.

November 10-11—British Columbia Conference, C.H.A., Vancouver.

November 12-15—British Columbia Hospitals Association, Vancouver.

December 16-20—A.C.S. Clinical Congress, Cleveland.

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* Santon Gilmour. (1937) *Tubercle, vol. 19, p.105.*

A rare case—admittedly: yet not without some bearing on problems in everyday practice.

For what can reasonably be concluded about the attributes of an antiseptic that could be so used, for so long, and with such a result? Obviously it must have been highly bactericidal; it must have been non-toxic, even at full strength and even on prolonged contact with the pleura and the gastro-intestinal mucous membrane; it must also have been non-irritant and non-corrosive, for otherwise it would have increased the vulnerability of the tissues to the infection and inhibited the natural processes of healing.

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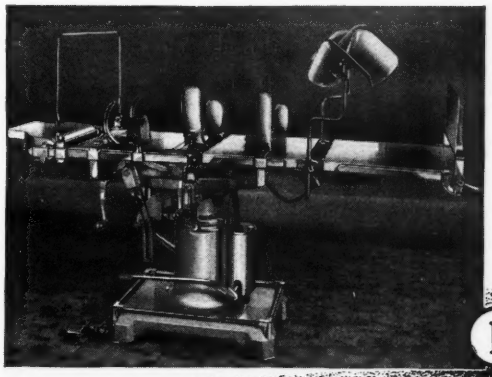

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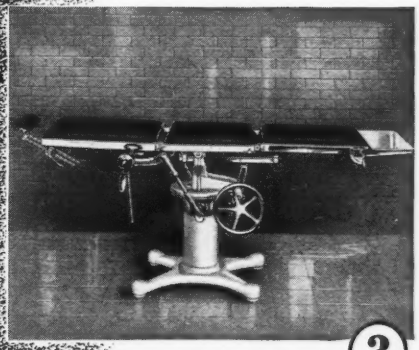

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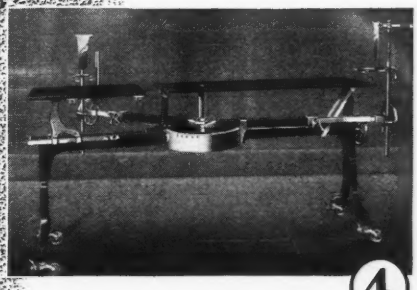

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Increasing Demands *being made upon our* MENTAL HOSPITALS

THE Annual Report of Mental Institutions for 1944, issued by the Dominion Bureau of Statistics, has just been received.

At the end of 1944, 59 institutions in Canada had the care and the treatment of the mentally sick and mentally defective. Of those 59 institutions, 32 mental hospitals, five training schools for mental defectives and two psychiatric institutions were under provincial control; county and municipal mental hospitals totalled 15, federal hospitals 2, while 3 were under private auspices.

In all these institutions there were in residence on December 31, 1944, a total of 47,279 inmates, of which 25,898 were males and 21,381 females. In addition to these 529 were boarding out and 3,968 were on parole, bringing the grand total to 51,776 on the books of all institutions on the above date, an increase of 648 over the total for December 31, 1943. Total normal capacity is given as 42,500.

Of the 51,776, 44,558 were in provincial mental hospitals, 4,313 in training schools, 88 in psychiatric hospitals, 1,693 in county and municipal hospitals, 901 in federal hospitals and 223 in private institutions.

A classification of the 47,279 patients in residence according to mental status shows that 35,869, or 75.8 per cent, had mental psychoses; 10,392, or 21.9 per cent, were mental defectives; 729, or 1.5 per cent, epileptics and 289, or 0.8 per cent, "all other types". Of the 35,869 with psychoses, 19,817, or 55.2 per cent, were males and 16,052, or 44.8 per cent, were females. Of the mental defectives 53.0 per cent were males.

The number of persons in residence per 10,000 of the mean population was 39.5, showing a similar ratio to that of 1943.

Omitting transfers to other mental institutions, which numbered 1,150, total separations, including direct discharges and deaths, totalled 11,071. Deaths in hospital were 3,174, a decrease of 165 from 1943. The surplus of admissions over separations during 1944 was 728, and on December 31, 1944, the excess of patients in residence over normal bed capacity was 4,779.

The highest number of first admissions recorded during the fourteen-year period was in 1944 when 9,170 were received. The second highest number was in 1936 when 9,002 were admitted, while the average number for the period was 8,788. Nineteen forty-four also showed the highest number of readmissions with 2,629, the average for the period being 2,286.

Of the 7,897 direct discharges, 2,083, or 26.4 per cent, had recovered when discharged; 3,889, or 49.2 per cent, were improved; 1,358, or 17.2 per cent, were discharged as unimproved and 567, or 7.2 per cent, were discharged as without psychosis and not classified. Females show a much higher percentage of recovery than males in each year under review, the average for males being 24.3 and for females, 31.1.

Total expenditures for 1944 amounted to $21,877,537, of which $19,862,556 was for maintenance of patients and $2,014,981 for non-maintenance. Excluding non-maintenance expenditures and based on the daily average number under care, the annual per capita cost of maintenance of patients in institutions devoted exclusively to mental diseases was $369.

Total personnel numbered 9,007, an increase of 4 per cent over the number employed in 1943. There were 41 medical superintendents and 19 non-medical. The administrative staff, which includes superintendents, matrons, stewards and clerical employees totalled 461. The professional staff totalled 326, of which 119 were full-time physicians and 55 part-time; 32 medical interns (13 full-time and 19 part-time); 43 dentists (16 full-time and 27 part-time) and 77 in other groups. There was a nursing staff of 5,260, of which 935 were graduate nurses, 1,114 student nurses and 3,211 attendants; also 28 dietitians, 77 occupational therapists, 94 teachers and social workers and 2,761 other employees. Of this total personnel, 4,794 were males.

In the hospitals devoted exclusively to mental diseases, there was one doctor for every 228 patients and one graduate nurse to every 54 patients; of all other nurses and attendants there was one to every 11 patients, while of the total staff there was one for every 5.5 patients.

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Canadians who empty canned foods from metal containers as soon as they are opened may be surprised to learn that the food is just as wholesome and less liable to contamination if left in the can.

The Canadian Department of Agriculture, in a bulletin entitled, *Canned Fruits and Vegetables for Variety in Everyday Meals*", states: "Canned fruits and vegetables may be safely left in the can after opening". In a more detailed report, the United States Department of Agriculture says:

"It is just as safe to keep canned food in the can it comes in—if the can is cool and covered—as it is to empty the food into another container. Thousands of housewives are firm in the faith that canned food ought to be emptied as soon as the can is opened, or at least before the remainder of the food goes into the refrigerator—one of the persistent food fallacies.

"Cans and foods are sterilized in the (canning) processing. But the dish into which the food might be emptied is far from sterile. In other words, it may have on it bacteria that cause food spoilage. Whether in the original can or in another container, the principal precautions for keeping food are—keep it cool and keep it covered."

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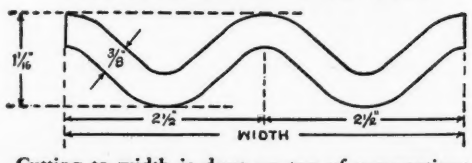

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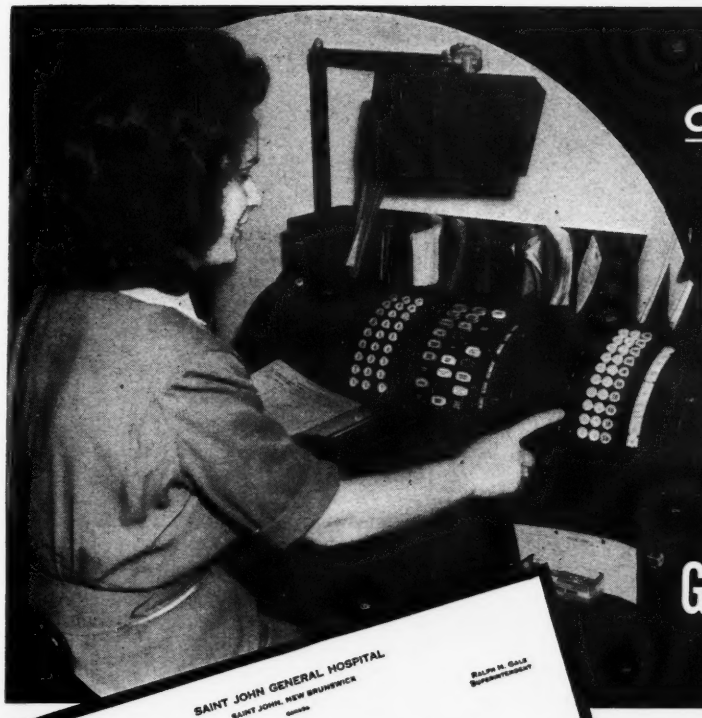
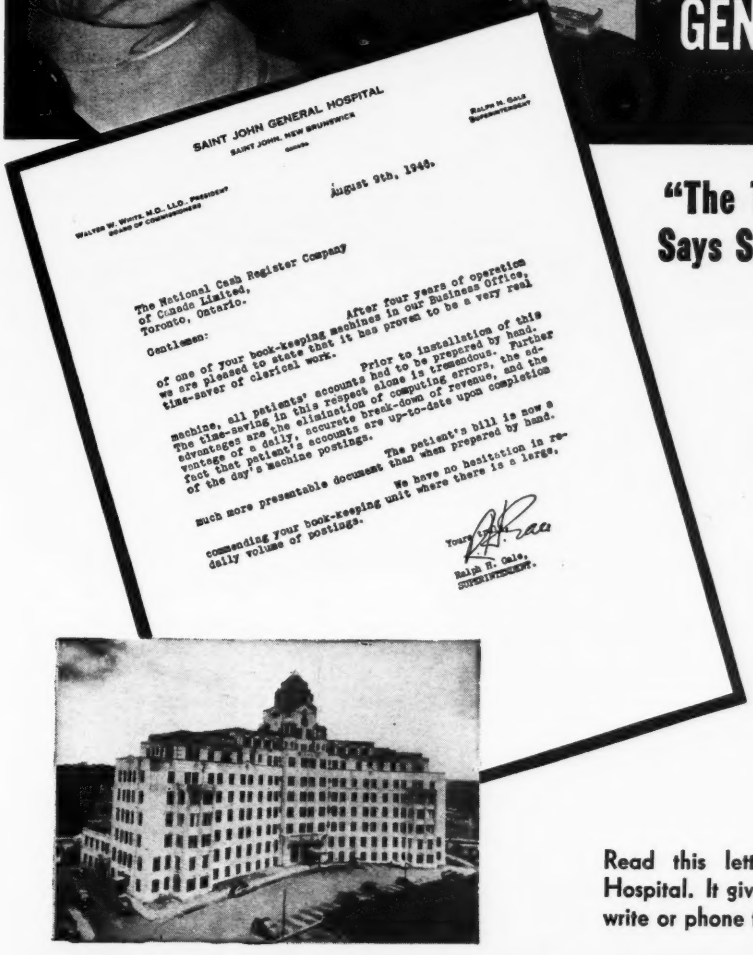


National establishes new efficiency standards in SAINT JOHN GENERAL HOSPITAL



SAINT JOHN GENERAL HOSPITAL
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"The Time-Saving is Tremendous" Says Superintendent Ralph H. Gale

●The modern hospital can't afford to be old-fashioned in its professional techniques. Neither can it afford to be backward in its business methods.

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Read this letter from Saint John General Hospital. It gives many reasons why *you* should write or phone the National representative.

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The Nurses' Strike
at Belleville Hospital

THE situation at Belleville (Ontario) General Hospital last month, when some 33 staff nurses left the hospital and their patients over the question of salary, hours and sick leave, is of considerable interest to hospitals elsewhere and has caused concern to leaders both in the nursing and in the medical professions. It is unfortunate that this incident received so much press publicity, for it might easily influence irresponsible elements among nursing groups elsewhere to forget their professional responsibilities.

The prevailing salary schedule was lower and the hours of work longer than those in numerous other hospitals. The nurses had a legitimate reason for asking for changes. This was realized by the Board, which wrote to a number of comparable hospitals and offered to the nurses a schedule of salaries and working conditions which was the average of some twenty-five schedules received. This offer, if it was really made, was not acceptable to the nurses and they resigned, and quit, en masse on September 9, leaving the patients without adequate nursing care, although no mention of resignation had been made at any meeting.

After further negotiation it was agreed that they would come back until October 16, receiving in the interval a $20.00 per month increase, retroactive to September 1st. It is reported that they threaten to walk out again at that time if they do not receive a $25.00 increase, a straight eight-hour day (some are on split shifts), free hospitalization and 12 days' cumulative sick leave instead of seven each year. Meanwhile, following the resignation of Mr. Gordon Barclay as administrator, the former administrator, Mr. Gordon A. Friesen, recently returned from Germany, has agreed to take over for a month or two during the reorganization period. We understand that an almost complete reorganization is under way.

Some Observations

Whether the demands of the nurses beyond the interim adjustment are just or excessive is not for us to say. Salary and working conditions are changing so rapidly that what is "normal" or "fair" is not easy to determine. But there are some features of this situation which are regrettable.

As to whether the nurses went on "strike" or merely "resigned" is largely an academic quibble. For practical purposes they staged a *strike*, call it what you may. When people resign positions they do not stay around arguing about salary increases for several days, finally accept an increase and return at 7 a.m. the following morning. Nor do they resign without giving proper notice in advance. We doubt that these young women would really have "resigned" if there had been a likelihood that the hospital could replace them.

These nurses and others may feel that they can thus avoid the odium of having betrayed their professional obligation not to desert their patients, but the result to the helpless patient is just the same. The primary purpose of the hospital and its staff is to care for the sick patient.

The nurses were not as "tough" in their demands as some reports would indicate. They might well have been better off without certain outside assistance for their memorandum, obviously prepared on legal advice, was so phrased as to cause much irritation to the Board.

It is unfortunate, too, that the nurses took matters into their own hands rather than work through their provincial nurse organization. Matters of this nature cannot be settled on a local basis only and it is much better in situations calling for collective bargaining to have that done through their professional organization. It is a sign of the times that there are many without the nursing profession, and some within it, too, who would have the nurses forsake their professional status and become a trade union, its members distinguishable only by a number.

When called in, Miss Jean Masten, president of the R.N.A.O., did much to clarify the situation, as did Miss A. M. Munn and Dr. James Stalker of the provincial Department of Health. But it would have been better if, instead of making this a public matter by calling in the Government, the administration had called in the provincial nurse and hospital associations at once, as proved so satisfactory in London some time ago. A joint committee could have been most helpful.

For the record it should be noted that press reports indicating that Miss A. M. Munn, director of the nurses' registration branch of the provincial Department of Health, was in full sympathy with the strike were completely without foundation. Miss Munn made no statement to the press.

Nor did members of the local medical staff improve future relations with the board of trustees by letting reporters draw from them strongly-worded opinions on the situation. Full comments made are seldom printed, and extracts, true or distorted and separated from their context, all too often add only to the heat of controversy, to the embarrassment of the spokeman and a beclouding of the issues. The medical men can accomplish much more by conference with the trustees rather than through the press.

Two-thirds of a Million!

The Ontario Plan for Hospital Care had an enrollment by the end of July of 666,063 participants. Many of the groups now enrolling are from small centres.

Blue Cross Commission reports for the second quarter of 1946 indicate that Ontario stood fifth among those showing a gain of 50,000 or more participants during the quarter. Ontario's gain was 66,550.

Among the plans showing a gain of 20,000 to 50,000, we note that Quebec stood second out of 19 plans with a gain of 40,928. The Maritime Plan stood seventh with a gain of 36,117.

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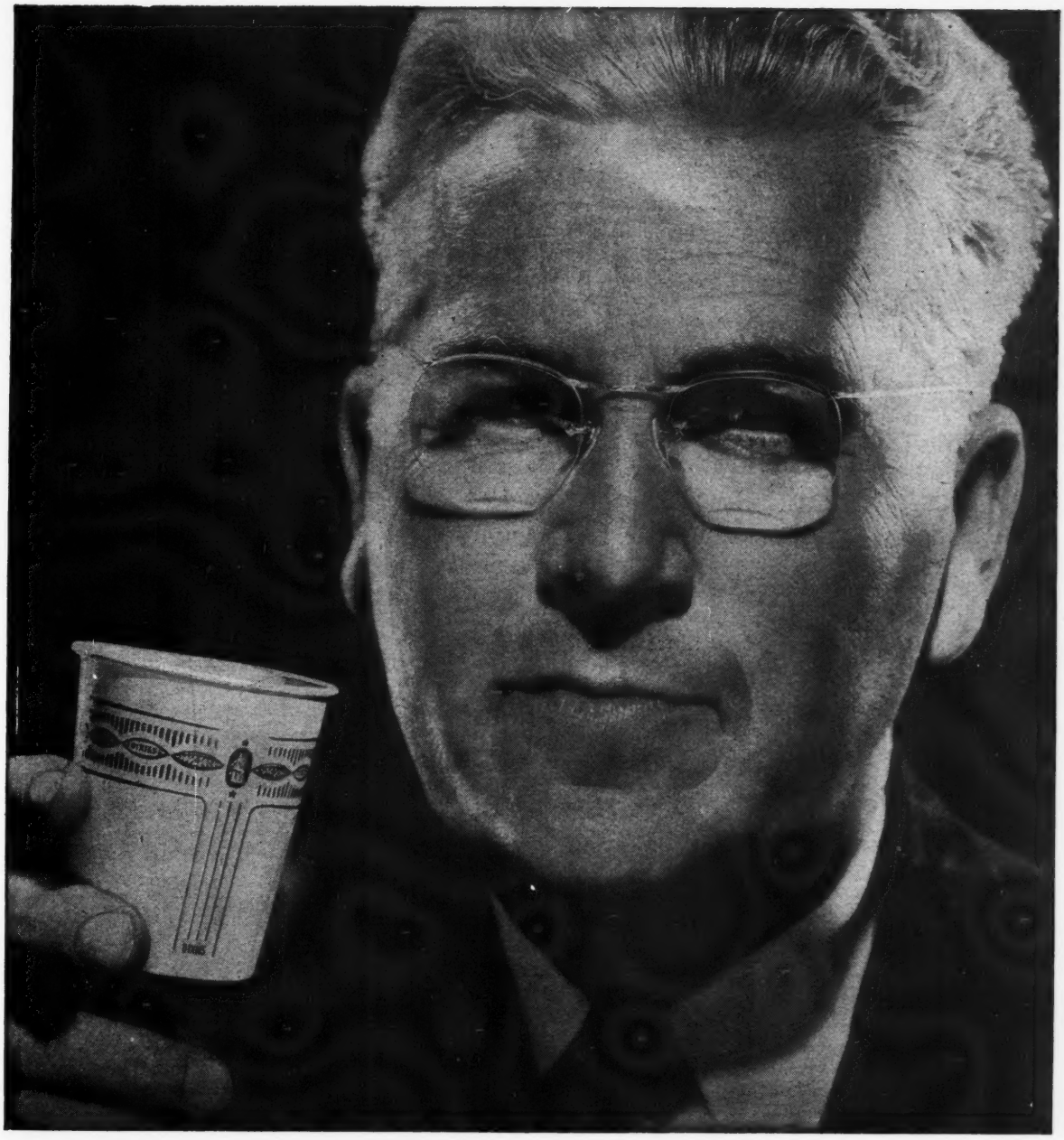

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Ontario Association Planning a Varied Programme

THE plans for the convention of the Ontario Hospital Association, October 21-23, have now been completed by the program committee under the chairmanship of Miss Pearl Morrison. It is hoped that delegates will be present early on the first morning to attend the eight o'clock breakfast meeting of the Women's Hospital Aids Association. At this breakfast meeting Mrs. H. M. Aitken will be speaker and Mrs. M. J. McHugh will be soloist. The first morning session will be of unusual interest, for there will be a symposium on personnel relations, the speakers being Mr. E. E. Sparrow, chairman, Board of Trade Industrial Relations Committee; Mr. C. K. Lally, general supervisor of labour relations, Bell Telephone Company, Montreal; and Mr. A. J. Swanson, president of the Canadian Hospital Council. In the afternoon delegates will have a chance to visit Sunnybrook Hospital.

The Tuesday morning Nursing Section will also be of special interest, for the various papers will deal with the present nursing situation in hospitals and proposed solutions to some of the problems. Concurrently with this section on nursing, the Dietetic Section, the Women's Hospital Aids Association and the Canadian Association of Medical Record Librarians will be meeting.

During Tuesday afternoon reports of the success of the Regional Conferences will be presented, and there will be a discussion on "Why and how pension plans are necessary for hospital employees".

Mr. O. Smith, the Association's Advisory Accountant, will be on hand to answer questions on accounting problems.

The banquet speaker on Tuesday evening will be Dr. F. W. Routley, National Commissioner of the Canadian Red Cross Society, who will speak on his observations during his European tour this summer. As usual there will be musical numbers and a floor show at the banquet, to be followed by a dance and the showing of selected films.

The programme will be continued this year during the afternoon of the third day, a symposium on construction being held that afternoon with Mr. H. Gordon Hughes of Ottawa, Dr. John C. Mackenzie of Montreal, Professor Eric Arthur, University of Toronto Professor of Architecture, and others participating.

There will be a luncheon each day, Dr. MacEachern's big Round Table will be on the third morning, and a varied and interesting program of papers and discussions has been planned for all three days.

The **Canadian Association of Medical Record Librarians** will be meeting on the 21st and 22nd. The **Women's Hospital Aids Association** will also be meeting on those two days, with an evening meeting on the 21st.

* * *

Mrs. Rhynas to Retire

Mrs. Oliver Rhynas of Toronto, formerly of Burlington and Bayfield, will retire this month as president of the Women's Hospital Aids Association of Ontario. Mrs. Rhynas has been retained in this position for seventeen years and, during that period, has been responsible in large part for the amazing growth and strength of this organization.

The secretary-treasurer, Mrs. George W. Houston of Hamilton, who has served for approximately the same period, will retire at the forthcoming meeting and also Miss Theo MacKelcan of Hamilton, the recording secretary.

Antivivisectionists Scored by Diabetic Experts

The attitude of those who would prevent the use of animals in the furtherance of medical research was strongly condemned at a meeting in Toronto last month of the American Diabetes Association, whose sessions marked the twenty-fifth anniversary of the discovery of insulin.

The large gathering of 400 doctors from all over the world unanimously approved a resolution requesting "all enlightened citizens to refrain from supporting the misguided efforts of so-called antivivisectionists who constantly try to hamper the advancement of science".

A strong tribute to the role played by animals was paid in the clause *"Whereas* the great work of Banting and Best in discovering insulin, and the subsequent scientific investigations clarifying its actions and uses, would have been impossible without the use of dogs and other domestic animals as experimental subjects; *therefore, be it resolved* that the American Diabetes Association hereby testifies to the value of the use of dogs and other domestic animals for purposes of scientific research."

The danger of restrictive legislation, almost put through in several states, was emphasized. Had some of these legislative proposals gone through, medical research in the universities and hospitals in those states would have been eliminated in a number of fields and drastically curtailed in others.

An ounce of inquiry is worth a ton of acquiescence.—*Ernest Wood.*

Ontario Conference Meets in Toronto

The Ontario Conference, C.H.A., will meet at St. Michael's Hospital, Toronto, on October 23rd and 24th. As usual the meeting has been planned so that out-of-town delegates can also attend the sessions of the Ontario Hospital Association.

A thorough discussion of all angles of the hospital's relations with the public and with its employees will feature the two-day convention. One of the chief speakers on this subject will be Sister Anne Catherine, of the Mother House of the Sisters of St. Joseph at Carondola, Mo. "Labour Relations in Hospitals and the Hospital's Responsibilities" will be dealt with by Mr. Henry Somerville of Toronto, while the Right Rev. Basil Markle will address the delegates on "Personnel Problems in the Post-war Period".

One of the highlights of the sessions will be a discussion of "Psychiatry as it Relates to the Education of Student Nurses", by Dr. J. G. Dewan of the University of Toronto. Dr. Harvey Agnew will speak on "Hospitals Today and Tomorrow".

The delegates will attend Mass on the morning of Thursday at 8.30.

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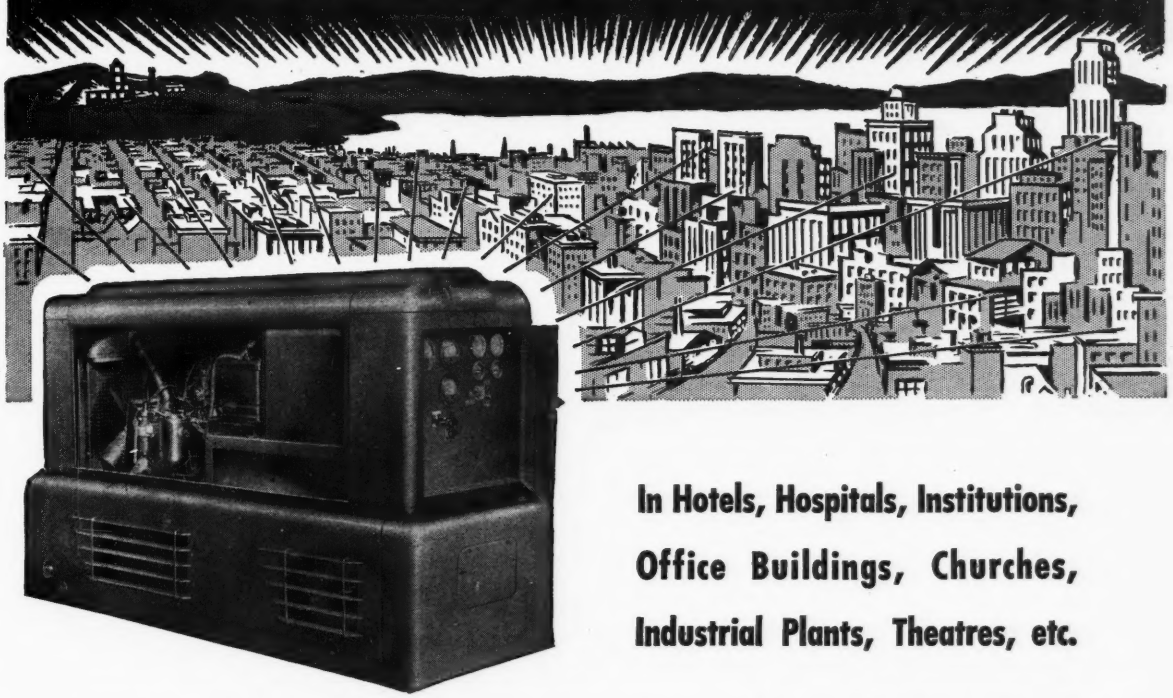

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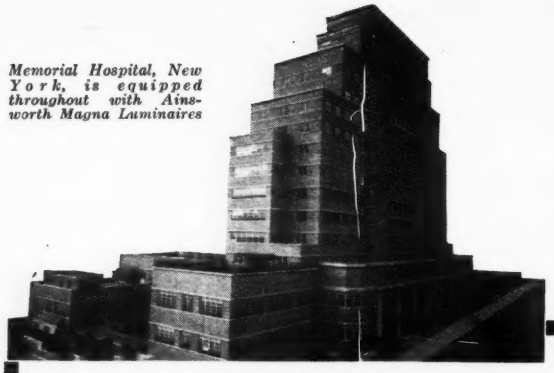

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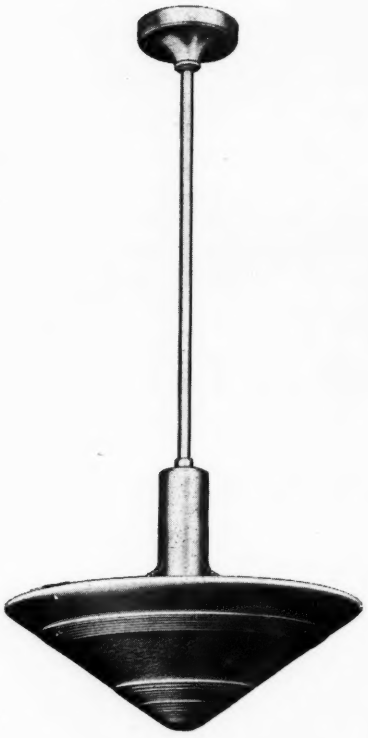

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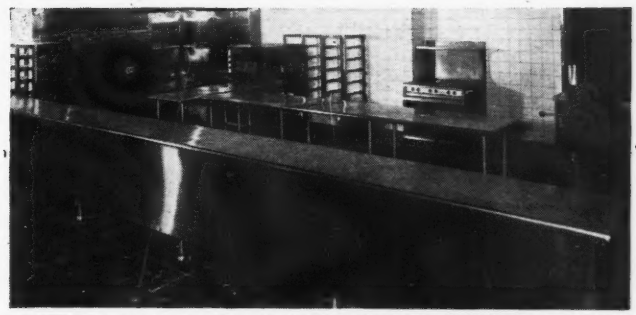

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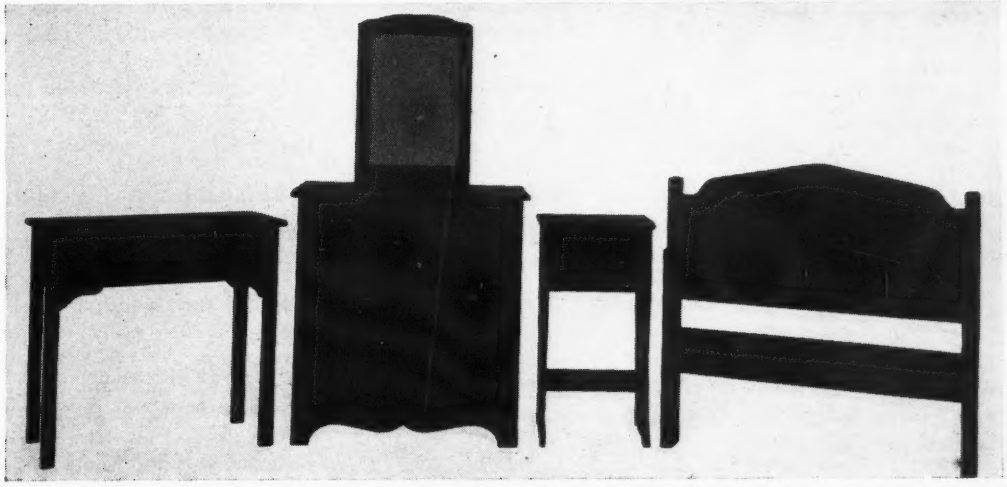

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A Point Rating System

The Evaluation of Salaries

A PERPLEXING problem in all institutions and organizations is that of setting salaries for various positions which will provide a return to the individuals concerned in accordance with the training and experience required and which will consider the degree of responsibility, initiative and other factors required. In many instances, prevailing rates in the region may be a factor, or perhaps supply and demand, but the whole picture would be greatly improved if salary levels, scientifically determined and subject to some flexibility, could be set for beginners in different categories. This might be applied in some considerable degree to hospitals.

A point rating system which would seem to have definite merit has been worked out by Canadian Breweries Limited. Basically the scheme determines the salary for each position in proportion to the extent to which certain standard qualifications are required for the job. These factors are analyzed for each position as outlined below and, after due weighting, minimum, normal and maximum salaries are set up. Hourly-wage employees are not covered as their wages would be determined by the union scale.

In assessing the relative value of different positions, nine different qualifications or factors were considered. It was realized that these were not of equal importance for the type of work under consideration and, therefore, these factors were weighted to indicate their relative importance:

	Points
1. Mentality	120
2. Creative and Directive Ability	150
3. Experience	150
4. Resourcefulness	150
5. Judgment	150
6. Responsibility	100
7. Personality	100
8. Quality (additional)	40
9. Physical and/or Mental Effort and Type of Working Conditions	40
	1,000

This point evaluation would vary with the industry. For instance a comparison with similar plans in other fields reveals that the aircraft industry would give 500 points for experience, 240 for Item 9, and none for resourcefulness or personality. Banking gives 244 points for judgment and 317 for personality; none are assigned for mentality but that should not be construed as a reflection on bankers. The electrical industry breakdown gives 160 points as a base, as has been proposed for the point system for the payment of hospitals.

Each position—plant accountant, foreman, shipper, etc.—was then analyzed and points assigned. Under "mentality" if two years' high school training is enough, assign 20 points; if high school plus business or vocational course is required, 60 points. Under "experience" if one year only needed, assign 20 points, four years 90 points, and ten years 150 points. By means of graphs the point total of each post was given a dollar evaluation, a basis being selected which gave a general result in keeping with prevailing community levels. These were then checked against actual salaries being paid and were found to be generally in line.

From these graphs were set up "normal" salaries for each position. Beginners start 15 per cent below the normal for that job and highly satisfactory employees may go to 15 per cent above normal.

Old employees were disturbed very little. None were reduced; all got at least minimum pay or higher. New employees start between the minimum and the normal.

Rating the Individual

So much for determining the relative remuneration of various positions. How about rating the individual so that he may get adequate credit for his training and experience and for his ability to meet his responsibilities? Personal initiative, resourcefulness and conscientious devotion to duty should merit increases.

The C.B.L. plan evaluates the position only. The merit of the individual is recognized by a more rapid approach to the maximum or by transfer to a position with a higher point rating. This plan could well be combined with a "merit rating" plan by which the individual, as well as the position, could be rated.

The Case for Co-operation

Even a small hospital can become a potent community force and a valuable educational centre for all physicians in the community, if properly organized and administered. The strategic placement of such hospitals throughout the country may do much to bring about better distribution of physicians' services—one of the admittedly difficult problems in providing adequate medical coverage for all the people. A development of this magnitude and importance requires painstaking study and planning lest it be wasteful of funds and ineffective in raising the quality of medical care, which is its main objective. Before many steps are taken, an exploratory evaluation would be desirable to ascertain how to relate the functioning of these hospitals to local needs and local means, and whether each individual unit could be tied up with a co-operative regional scheme of peripheral, intermediary and central or key hospitals, similar to that worked out in New England under the aegis of the Tufts Medical School and the Bingham Associates, or the one proposed in Great Britain by the Nuffield Trust.

—E. H. L. Corwin in "The American Hospital".

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(1) Cullen, S.C.: Anesthesiology 5:166 (March) 1944.
(2) Griffith, H.R.: J.A.M.A. 127:642 (March 17) 1945.
(3) Griffith, H.R.: Canad. M. A. J. 50:144 (Jan.) 1944.

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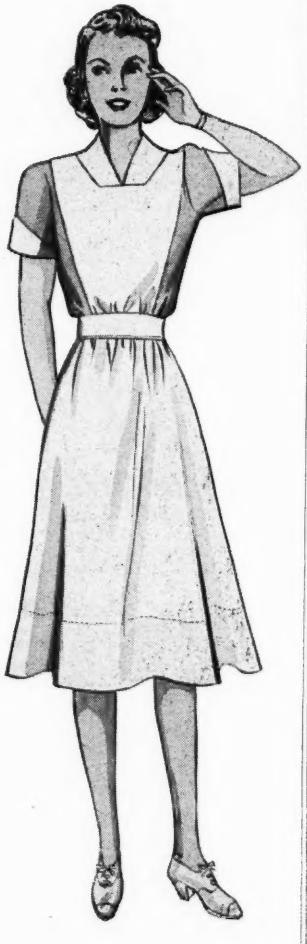

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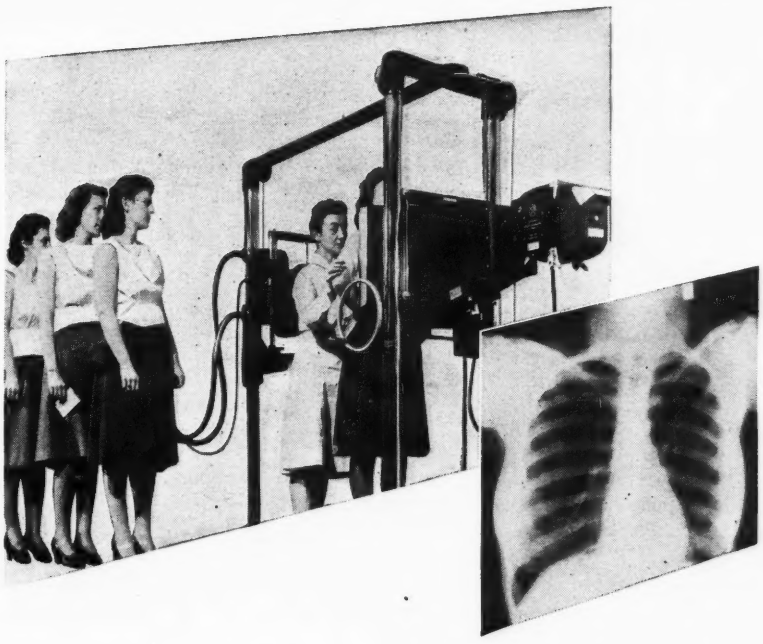

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To Build or Not to Build

(Concluded from page 30)

A western contractor, although not favouring temporary construction, did favour the *obtaining* of temporary quarters where such would be possible:

"I am definitely of the opinion that, unless there is a very urgent need indeed, hospital construction for the time being should be limited to an absolute minimum, and if it is possible to obtain temporary buildings, to make use of them."

In supporting permanent construction one maritime architect stated, "I am of the opinion that it should be built properly, regardless of its cost, for after all is not all this high cost today also accompanied by cheap money?"

General Comment

A number of very helpful comments of a general nature were made by those who replied to our questions.

Noting that the estimates of contractors are being figured too high in many instances at the present time, one architect attributes this to the fact that the present and past actions of trade unions have so alarmed the contractors that they feel they must figure high in order to protect themselves. "We are now advising our clients to let their contracts on a cost basis, whereby all accounts for labour and material are invoiced for the one particular job; these invoices are checked by the architect and then passed on to the owner with a receipt showing that all accounts have been paid for labour and material by the contractor. Before this type of contract is signed, the contractor agrees to accept a fee as his profit on the job."

Another writes:

"As an architect I think that many of our so-called established principles of hospital planning are outmoded and that a committee of hospital administrators and architects should be formed to get down to a fact-finding position and, if possible, submit a book on accepted minimum standards for hospital planning for wards, utility rooms, diet kitchens and all other services of a hospittal, and of materials used in construction, so that these excessive costs might be reduced by economies in plan and construction.

"Also, hospitals should be zoned in the various parts of our provinces so that they would only be built to take care of the immediate needs of a district rather than some grandiose hospital being erected to satisfy the whims of some district which cannot utilize the hospital to its full extent. Limited areas should restrict their hospitals to a size to take care of maternity, accidents and general sickness, but any major surgical, medical or expert services should be provided at a large general hospital within a reasonable distance from these smaller hospitals.

"Hospitals should not vie with one another to provide special services, but the services should all be arranged on a defined policy under some hospital authority. Consideration should be given in our hospitals to preventive work as provided in special clinics; if done, this no doubt would reduce the necessity for hospital bed accommodation."

An architect of experience gives the following helpful suggestions:

"The possible use of combinations of materials to reduce man-hours on the job, decrease the rate of heat transmission, winter and summer, provide greater flexibility to facilitate changes in the use of the structure as hospital management is called upon to meet new conditions.

"Greater use of the space and equipment that can be provided under increased costs. Rooms that are in use for only a few hours daily, or even less, as in the case of Board Rooms, rooms for meetings and such like, duplication and triplication of sterilizing facilities for which it is practically impossible to provide adequate trained personnel—all are factors seriously influencing the cost per bed.

"If buildings planned and built 50 years ago are no longer suitable for modern hospital use, are we justified in thinking that what we build now will meet the requirements of 50 years hence?"

Acknowledgment

Grateful acknowledgment is made to the following who replied to our enquiry:

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J. Kenneth Gillies, of Alward & Gillies, Saint John, N.B.

J. L. E. Price, of J. L. E. Price & Company, Limited, Montreal.

Harold J. Smith, Architect, Toronto.

H. C. Nicholls, President, National Construction Council of Canada, Toronto.

C. Blake Jackson, The Jackson-Lewis Company, Toronto.

James Govan, of Govan, Ferguson & Lindsay, Architects, Toronto.

H. J. Bird, Bird Construction Co., Limited, Winnipeg.

Stanley E. Storey, of VanEgmond & Storey, Architects, Regina.

Dan H. Stock, of Portnall & Stock, Architects, Regina.

C. W. Alston, Poole Construction Company, Limited, Edmonton.

Richard P. Blakey, of Blakey, Blakey & McKernan, Architects, Edmonton.

Frank G. Gardiner, of Gardiner & Thornton, Architects, Vancouver.

H. Whittaker, Chief Architect, Department of Public Works of British Columbia, Victoria.

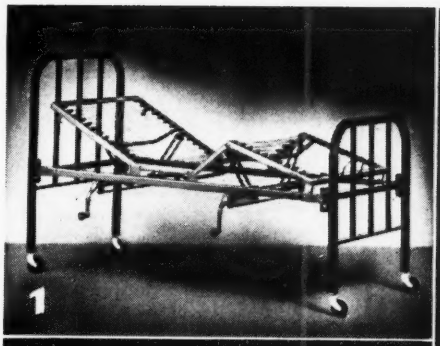
$50,000 Grant Made to A.C.H.A.

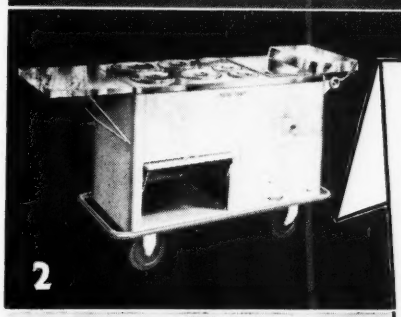
The National Foundation for Infantile Paralysis has formally announced the award of a five-year grant to the American College of Hospital Administrators. Dr. Munger, President, had requested the grant in behalf of the College and its program. It is effective as of July 1, 1946 through June 30, 1951.

Payable in annual instalments of $10,000, the purpose of the grant is to extend and strengthen the activities of the American College of Hospital Administrators in respect to its program of institutes for hospital administrators. Provision is also made for the development of informational material including a monthly news bulletin. The initial instalment of the grant has been transmitted to the College by the Foundation, and the Executive Committee now has plans under way for the practical utilization of these funds.

Erratum

In the September issue of *The Canadian Hospital,* page 41, under the heading *Saskatchewan Hospitals Protest Student Nurse Salary Order* the first sentence of the second paragraph should read: "Strong protest is being made also against the ruling that the *maximum* that can be charged for meals is to be twenty cents . . . . . "





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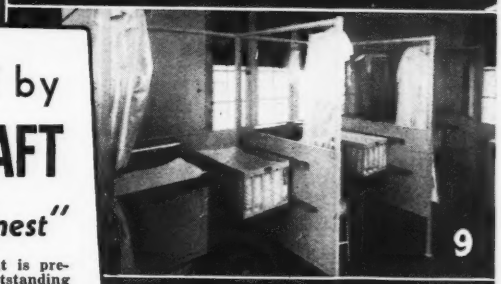

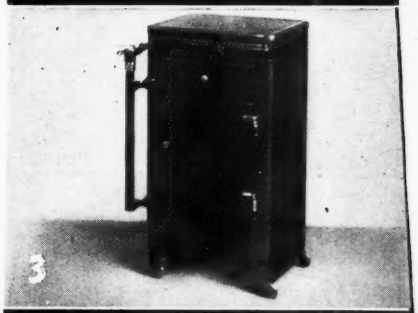

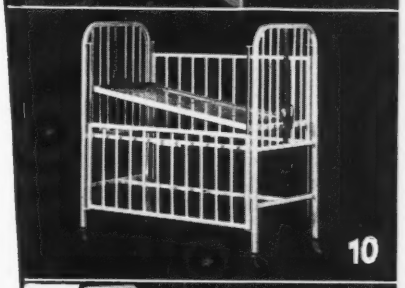

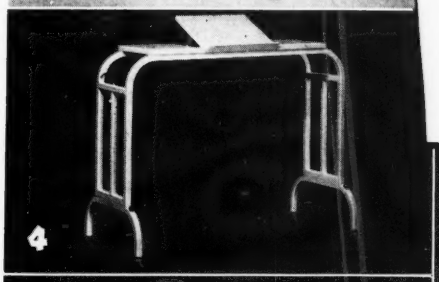

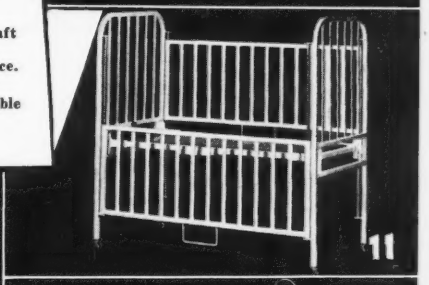

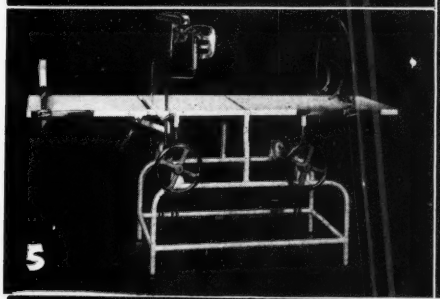

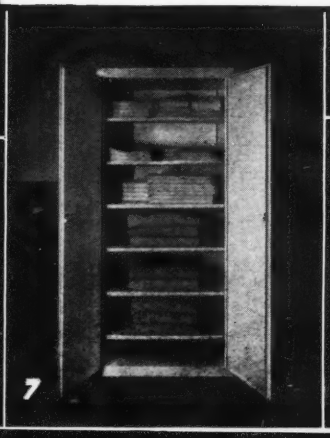

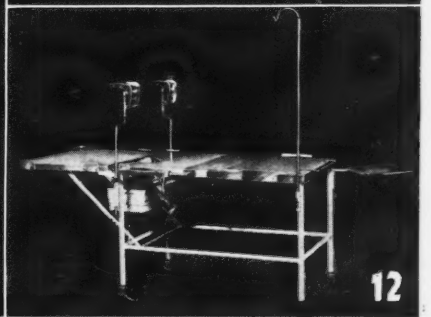

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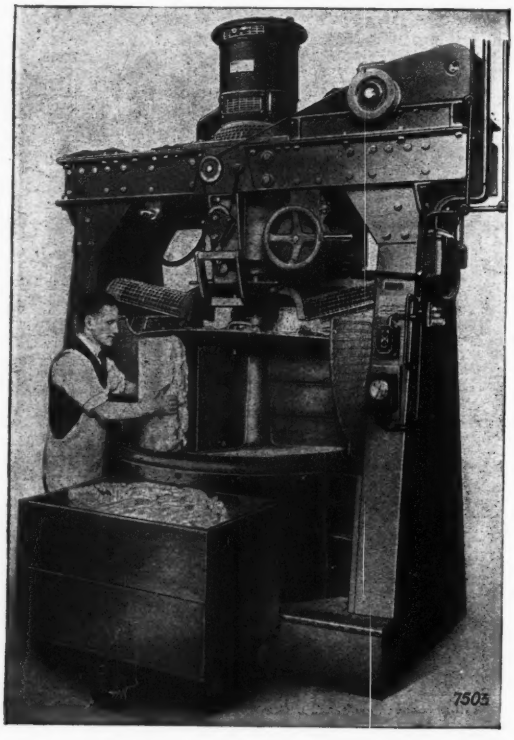

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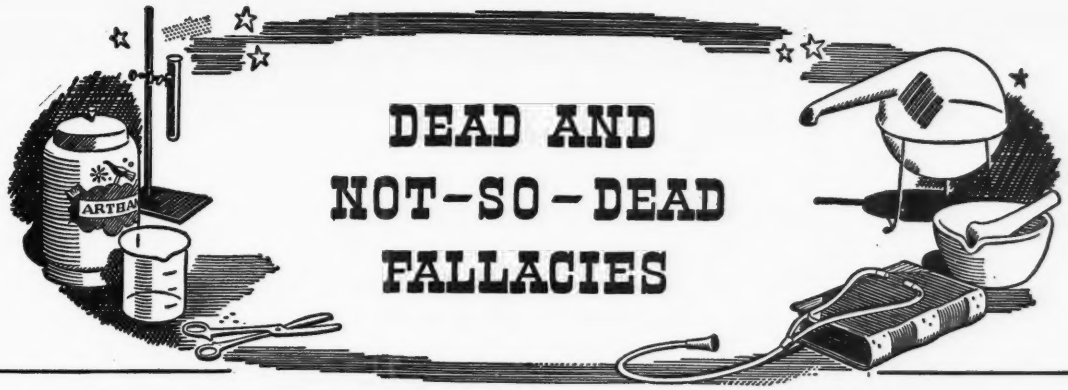
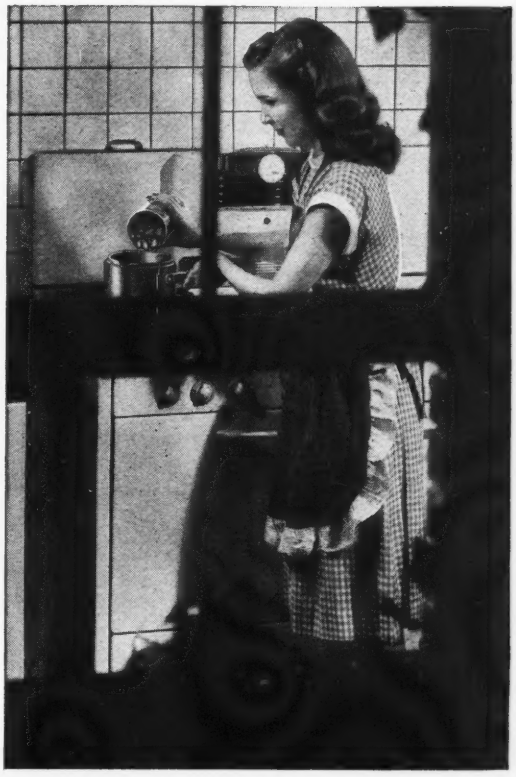


DEAD AND NOT-SO-DEAD FALLACIES

A sty, according to an old belief, should be treated by having it licked by a dog. When this treatment failed, the patient might try striking it nine times with a tomcat's tail, or rubbing it with a wedding ring.



Still widespread among people of this generation is the idea that canned foods should be cooked. This, of course, is not so—for, in the canning process, foods are thoroughly cooked. To serve, they need only be heated and seasoned to taste.

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Address.....

City.....Province.....

Provincial Notes

(Continued on page 92)

New Brunswick

HARVEY STATION. A new community hospital with a capacity of 15 beds will be opened in Harvey this fall. The building is the gift of Mr. and Mrs. D. G. Taylor and Mrs. T. J. Walthall of San Antonio, Texas, who donated their former home in this village to the Harvey Community Hospital Association during a recent drive for funds to build a hospital. The grounds which surround the house are sufficiently large to allow for future expansion. Eleven thousand dollars has been raised locally and a two-storey annex to the main building will be completed, it is hoped, before the end of this year. The Canadian Red Cross has assisted with equipment and has offered to staff the new hospital with trained personnel, taking over its operation until the local committee is in a position to assume that responsibility.

* * *

MONCTON. The board of directors of the Moncton Hospital has unanimously approved the action of the city council in seeking legislation to permit cutting the number of directors from the present twenty-five to eleven, two of whom would be appointed annually by the council. This proposal followed the city's decision to guarantee the hospital bonds used for the building of an extension to the present hospital.

* * *

SACKVILLE. The new Sackville Memorial Hospital has been officially opened and is now in operation. This 25-bed institution is the first public hospital in eastern Westmorland county. It is a two-storey brick building and includes a well-equipped operating room and x-ray department. The superintendent is Miss Jeannie Murdoch.

* * *

SUSSEX. Dr. George E. Madison of Moncton has been appointed as tuberculosis consultant for the D.V.A. hospital at Sussex. Dr. R. J. Dolan of South Nelson, N.B., is superintendent. This 200-bed institution (formerly military hospital for Camp Sussex) was opened in August as a sanatorium for tuberculous veterans of New Brunswick.

Nova Scotia

AMHERST. Highland View Hospital has taken on a freshened appearance since the completion of the reprocessing of its exterior walls. The old stucco, which had been falling under weather action, was stripped down to the brick work. A steel netting was then fastened to the building by pins and under compressed air a concrete finish was applied and built up. The new surfacing will not only waterproof the finish of the structure but will make a warmer building and the hospital has been greatly improved in appearance.

* * *

PUGWASH. A large area of Cumberland County with its centre at Pugwash is planning to establish a cottage hospital in conjunction with the provincial Red Cross public health program. It is estimated that $10,000 must be raised to provide a building and the Red Cross will contribute the equipment. The hospital would handle minor surgery and all medical and obstetrical cases. This area has hitherto been dependent for hospital care upon the over-taxed facilities of the hospitals at Springhill and Amherst.

Quebec

MONTREAL. Miss Mabel K. Holt, who since 1927 has held the post of superintendent of nurses and principal of the school for nurses at the Montreal General Hospital, retired on September 1st. Her successor is Miss Mary S. Mathewson who has served as assistant director of the McGill School for Graduate Nurses for the past 12 years. Miss Mathewson is first vice president of the Registered Nurses Association of the province of Quebec.

* * *

THREE RIVERS. Extensive enlargement of the Cooke sanatorium will bring the total number of beds to 340. The work, which was begun last June, is expected to be completed late in 1947 or early in 1948. The present wing, which was meant to accommodate 135 patients, is at present housing 150. The modern new wing under construction will have beds for 205. M. Arthur Lacoursière of Shawinigan is the architect, and the general contractor is M. Hector Auger.

Ontario

ENGLEHART. Most of the framework for the $45,000 wing to the Red Cross Hospital at Englehart is now in position but some time will elapse before it is ready for occupancy. When this wing is completed the capacity of the hospital will be increased from 12 beds to 38.

* * *

MEAFORD. Dr. John E. Godfrey of Seattle, Washington, has presented his cheque for $20,000 to a hospital committee appointed by the Old Boys and Old Girls Reunion Committee of Meaford. The money is given to assist in the establishment of a new and permanent hospital in this town. Dr. Godfrey suggested that a site be chosen which would provide ample space for landscaped grounds and future expansion.

* * *

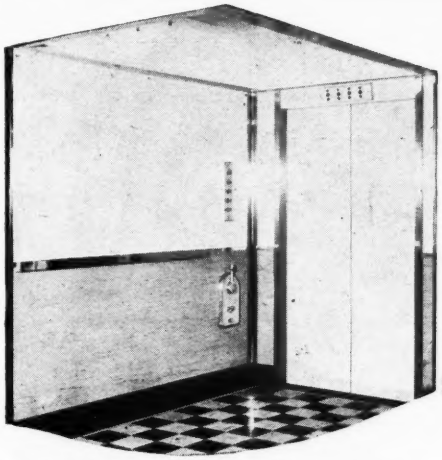
PERTH. Miss Grace Paterson of Toronto has been appointed superintendent of the Great War Memorial Hospital at Perth. Miss Paterson is a graduate of Toronto Western Hospital and was in active service overseas during the past War.

* * *

SMITHS FALLS. Ontario's new eastern hospital for mental cases is to be located in Montague township immediately adjacent to the town of Smiths Falls. The buildings will be erected on a level area overlooking the long and winding reaches of the Rideau river.

* * *

TRENTON. At a ceremony held on August 31st, the first sod was



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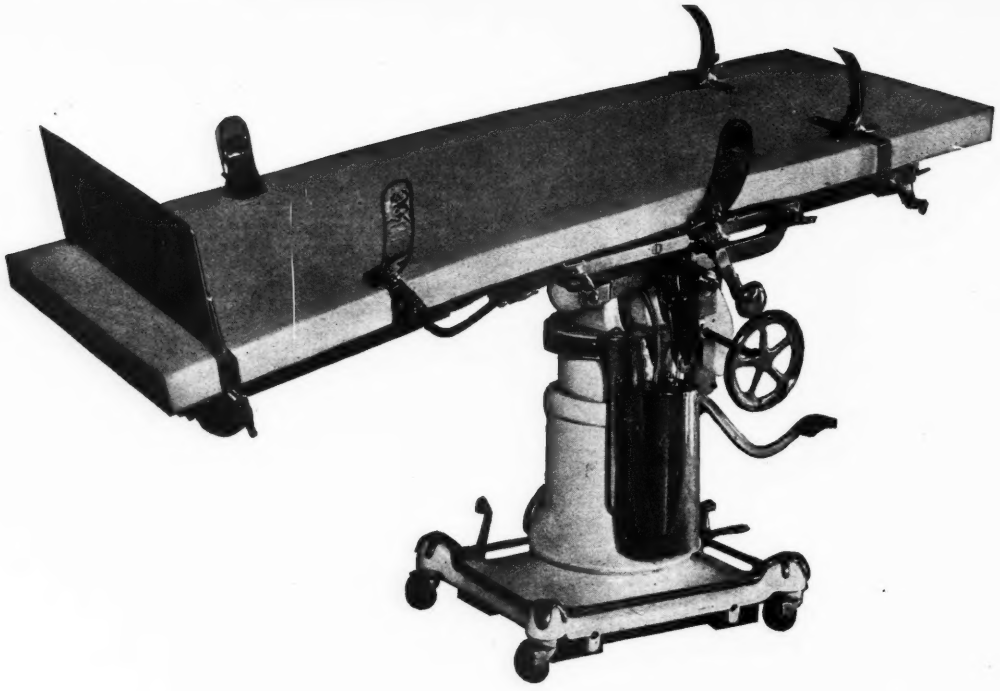

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*Vaposector Insecticide when dispersed by the Hydro-Mist Vaporizer can achieve a positive kill of such flying insects as Flies, Gnats, and Mosquitoes in areas of 500,000 cubic feet!

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VANCOUVER
WINNIPEG

Provincial Notes

(Concluded from page 88)

turned for the $200,000 Memorial Hospital at Trenton. It is the intention of the directors to go ahead with the foundation and get as much work done as possible before winter sets in. The hospital will be a three storey building, accommodating fifty patients and modern in every respect.

Manitoba

WINNIPEG. Under construction at the present time is a new $130,000 surgical wing for Grace Hospital. This addition is on Evanson Street at the rear of the main hospital building. It will provide 54 beds for surgical patients, new operating rooms and x-ray department as well as space for interns' quarters. Besides the surgical wing, one storey is being added to an older wing of the hospital and this space will be used as an obstetrical operating department. The architects are Moody and Moore.

* * *

WINNIPEG. Some months ago the erection of a new hospital for the infirm at a cost of approximately $650,000 was endorsed by a civic by-law and plans have now been completed by the architects, Moody and Moore. It is to be built on a site immediately south of the King George Hospital, facing south-west. The plans call for a three-storey chevron-shaped building with roomy sun balconies above the first-floor general offices. Two-foot deep cantilevers will protect the large windows from direct sunlight. The hospital will be connected by tunnel with the nurses' residence.

Saskatchewan

ESTEVAN. The proposal to use the airport hospital at Estevan as an auxiliary to St. Joseph's Hospital has been approved by the health planning commission at Regina. The building will accommodate about 35 patients and would help to relieve congestion at St. Joseph's.

INDIAN HEAD. Plans are under way for the construction of a new 30-bed hospital for acute diseases at Indian Head. It is proposed that the present Union Hospital be converted into a convalescent hospital and also function as a health centre with examination rooms. Both institutions would come under the care of the local hospital board.

* * *

REGINA. Additional hospital accommodation being made available this year in Saskatchewan will bring the number of hospital beds in the province up to 4,309 when the hospitalization plan goes into effect January 1st, 1947, Dr. C. G. Sheps of the Health Services Commission, said recently. The number of beds per 1,000 population will then stand at 4.8. In addition hospitals or wings now being planned or already under construction will provide another 1,149 beds, providing a very satisfactory total of 6.1 beds per 1,000 population. During the depression years there were only 3.2 hospital beds per 1,000 people in Saskatchewan and about one-half of these were empty much of the time because people were not able to pay for hospital treatment, Dr. Sheps said.

Alberta

PONOKA. A new municipal hospital, one of a total of fifty-one in Alberta, was officially opened by the Honourable W. W. Cross, M.D., Minister of Health and Public Welfare, at Ponoka on August 27th. Miss Ivy Morrell is matron and there is a staff of seven graduate nurses.

* * *

WAINWRIGHT. The proposal to build a new 50-bed hospital at a cost of $200,000 has received the support of the villages of Chauvin, Edgerton and Irma. The present 13-bed hostal in Wainwright is now accommodating 26 patients.

British Columbia

VANCOUVER. Plans have been prepared by the firm of Townley and Matheson for a six-storey addition to the nursing home at St. Paul's Hospital. This will be an "L" shaped building 106 feet deep with a frontage of 64 feet. The roof will be used as a sun deck. Construction will be of reinforced concrete with brick finish.

* * *

VANCOUVER. A survey of hospital resources in British Columbia is being made by Graham L. Davis, hospital director for the W. K. Kellogg Foundation of Battle Creek, Michigan. This survey is the first step in planning a long range program of hospital construction and remodelling, based on community requirements. Organizations interested in hospital planning have had the opportunity to present briefs and discuss with Mr. Davis the many problems involved, and much information has been collected for him by Mr. Percy Ward, chief inspector of hospitals.

Biochemistry and Cancer

The biochemist may have the answer to cancer in his test tubes. Certainly the surgeon, with all his mutilating operations, excellent though they are in the light of our present knowledge, leaves much to be desired. But the biochemist,—here is the hope for a complete solution to the cancer problem if, in truth, one can be found. Dr. Clarence Cook Little is authority for the statement that seventeen million people in this country now living will die from cancer and that five million can be saved by surgery or other means if they will present themselves in time to a well-trained doctor. What of the other twelve million and the endless millions to follow? The biochemist and his medical confreres in this field alone have an opportunity to enhance the welfare of mankind that beggars the imagination.

—Charles S. Kennedy, M.D., Journal of the American Medical Colleges. May, 1946.

There are only two sorts of doctors—those who practise with their brains, and those who practise with their tongues. *—Osler*

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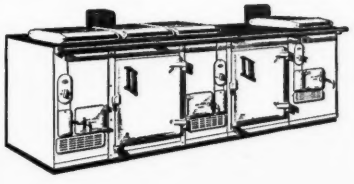

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- Even heat in the ovens.
- Automatically controlled cooking temperatures.

The flat bottom of this Cast Aluminum Stock Pot is twice as thick as the sides, so that it may be used for waterless or vapour cooking, as well as ordinary boiling and stewing. Food shrinkage is reduced and mineral elements retained, giving better flavoured foods. Can be ordered in a variety of sizes from 4 to 12 gallon capacity.

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◀ Book Reviews ▶

THE AMERICAN HOSPITAL By E. H. L. Corwin, Ph.D., Executive Secretary, Committee on Public Health Relations, The New York Academy of Medicine. Pp. 226. Price $1.50 (U.S.). Published by the Commonwealth Fund, 41 East 57th Street, New York 22. 1946.

This is still another volume in the valuable series being issued by the New York Academy of Medicine's Committee on "Medicine and the Changing Order". Much of this particular study is statistical and as it deals only with the hospital situation in the United States, the value of its major portion is limited here, except insofar as there is some parallelism with our national development. However in his later chapters the author does touch on a number of topics of definite application here.

The importance of increasing accommodation for the chronically ill is stressed and he notes that this can only be done if the Government takes an active part. He urges more cost accounting studies. Care should be exercised in the development of small hospitals. They can, however, do much to bring about a better distribution of medical care. There should be more pooled analysis of hospital medical statistics. Hospital designing should take into consideration the likely tendency of doctors to locate offices in the hospital block. More notice should be taken of the experiments in a number of cities whereby the members of a hospital staff conduct private practice on a co-operative basis.

This is a good reference work. If we have a criticism it is that he touches on too many important topics in the latter chapters without developing them sufficiently to make the references of real value except to those already familiar with these developments.

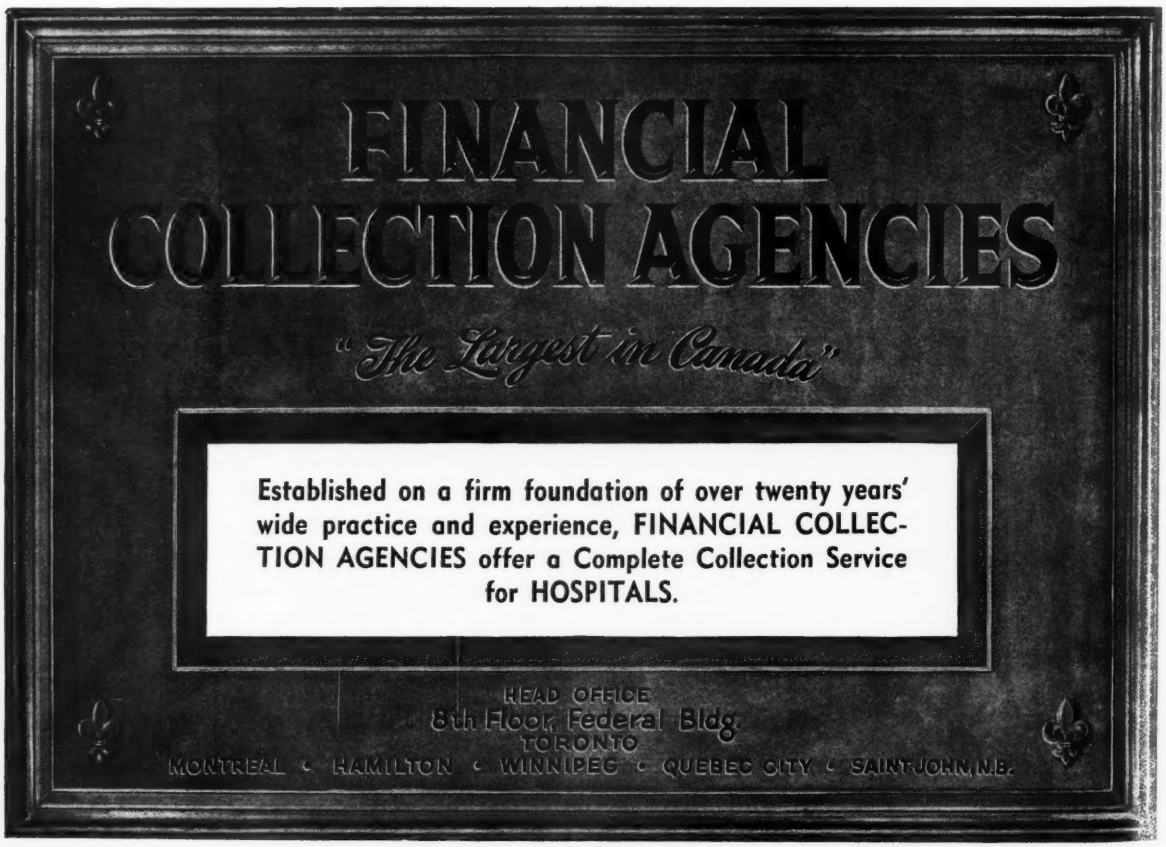
Venereal Disease Up

Over a thousand more cases of venereal disease were reported in Canada in the second quarter of this year than in the same period in 1945, the Hon. Dr. J. J. McCann, acting minister of National Health and Welfare, has announced.

"Although the most recent reports show a decline in new cases, venereal diseases continue among the top-ranking problems facing Canada today," Dr. McCann said. "This year the federal government has set aside over $270,000 to combat the V.D. menace, but legislation, money and medical skill are not enough. To eliminate this scourge requires an enlightened community and wholehearted co-operation, not only on the health front but equally on the moral, welfare and legal sectors."

In the first six months of this year 21,933 cases of syphilis and gonorrhoea were reported, of which 8,283 were syphilis. The total number of cases in the April-June quarter was 10,235 as against 11,698 in the first three months of the year. However, for the April-June period of 1945 total new cases of all types of V.D. were but 9,188.

The rate of syphilis for Canada is now 125 per 100,000. The rate of gonorrhoea is 210.8 per 100,000 population.



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Ownership of X-Ray Films

Radiologists issue statement on rights of patients and referring physicians.

LEGAL rights and ethics involved in the ownership and use of roentgenograms have long been a source of trouble to radiologists, referring physicians and hospitals. To clarify matters for all concerned, the board of chancellors of the American College of Radiology has announced the following ten-point statement of policy, adopted after study of the problem by a special committee:

1. Roentgenograms should be used for the patient's best interest.

2. Roentgenograms are the legal property of the radiologist or of the hospital in which they were made. It is advisable, but not necessary, to mark on each film the statement, "Property of Dr. John Doe". Such a mark is particularly desirable if the radiologist delivers the films to the referring physician instead of filing them in his own office or hospital department.

3. It should be the policy of the radiologist to make the films available for inspection by the physician who referred the patient for x-ray examination, along with a copy of the report of the radiologist. The best results are undoubtedly secured when it is possible for the radiologist and the referring physician to confer personally when the latter views the films.

4. If the referring physician (or the patient in behalf of the referring physician) wishes to take the films away from the office or the hospital, it should be clearly understood that the films are loaned and must be returned after the loan has served its purpose.

5. If the patient dismisses the referring physician and goes to another physician the films and the report should be made as freely available to the second physician as to the one who originally referred the patient. It is desirable that the patient notify the first physician of the change, and it may be assumed that he has done so; but even if this notification has not been made, the obligation of the radiologist is unchanged. When the second physician wishes to examine the films, it is assumed that he is doing so at the request of the patient.

6. If the referring physician objects to having the films made available to the second physician or to giving the latter a copy of the radiologist's report, the radiologist remains obligated to do so. If the referring physician has possession of the films and refuses to release them, the radiologist, whose legal property they are, has the right to take whatever action is necessary to get the films for the further benefit of the patient.

7. All films should be legibly and

(Concluded on page 98)

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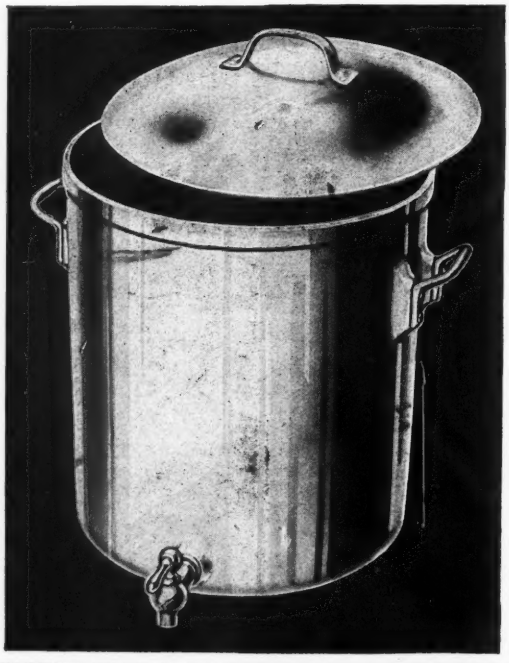

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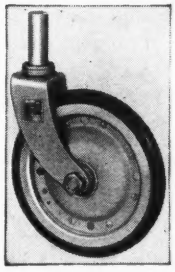

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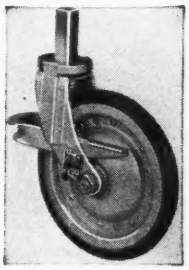

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Ownership of X-Ray Films

(Concluded from page 96)

permanently marked so that the patient can be identified and the date on which they were taken can be determined. This is important because, under some conditions, a comparison of films just made with others made previously may be the crucial factor necessary to establish a diagnosis or to estimate the progress or regression of a disease.

8. When a medico-legal situation exists, the radiologist has a right to refuse to release films necessary for his own protection, except when a court orders him to do so.

9. A liberal attitude regarding the release of films is more desirable than strict insistence on one's legal rights. It is better to run the occasional risk of losing films than to incur the enmity of a patient or of a physician by strict adherence to the rule (which in the past has led to attempts to pass laws making films the legal property of the patient).

10. In recognition of the universal importance of radiologic methods of examination, the principles regarding the use of roentgenograms outlined above are deemed by the American College of Radiology to be equally applicable to roentgenograms made by physicians other than specialists in radiology.

—from "Medical Economics", July, 1946.

The Cost of Striking

Some strikes are unavoidable because management refuses to bargain in good faith. The AFL maintains, however, that a strike should be the last resort, used only after genuine efforts at collective bargaining, conciliation and arbitration have failed. The reason for this is clear. Count the cost of a strike to the workers... Suppose the workers are earning an average wage of $1.00 per hour. The company offers an increase of 12c to $1.12, but the union turns down the offer because they think a government board may give them more. They go on strike and stay out for eight weeks.

Each worker loses an average of $358 (pay for 8 weeks of 40 hours at $1.12 an hour). At the end of that time the government board awards 18c, 6c more than the company offered. The company accepts the award and grants 18c, but it will take the workers nearly three years' work before this extra 6c will amount to enough to repay their loss. If, as seems more likely, the company refuses to accept the award and gives only 3c more (15c in all), then it will take the workers nearly six years of work before their extra 3c per hour will add up to the amount they lost by the strike.

If the extra 3c or 6c breaks a price ceiling, workers may take losses they can never regain . . . If, on the other hand, the workers had avoided the strike and used every means to build up a sound relationship of good will between their union and the company, and both had turned their attention to getting out production, they could have gained much more than the extra 3c or 6c in further wage increases. They could have saved their strike loss and won public good will.

—Monthly Survey, A.F. of L.

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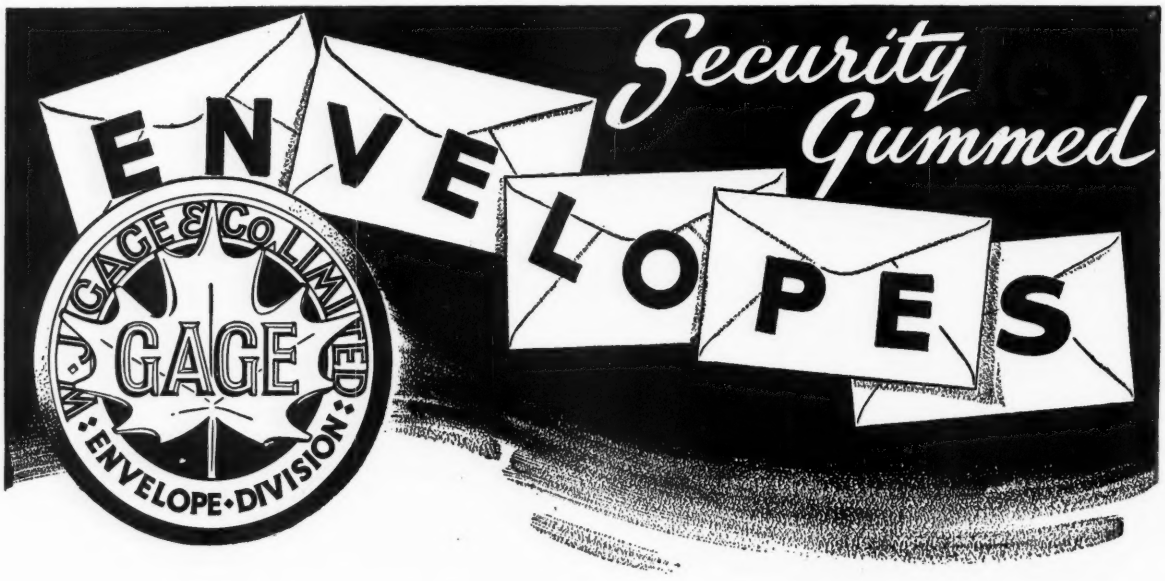

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Bailey—DEMONSTRATIONS OF OPERATIVE SURGERY FOR NURSES. $4.75.

Hamilton Bailey's great surgical skill and experience has now been made available to the nursing profession to the members of which he pays his tribute in the course of this volume. Many of the Demonstrations have appeared in the "Nursing Mirror" and received the unqualified approval of the nursing profession. Others included resulted from requests by nurses for the material they provide.

Correspondence

Help Needed

To the Editor:

. . . . Since returning I have been desperately busy. We are extremely short handed, and that makes added work for those who are here. Our wartime guest institutions are leaving or have already left for the East, and the going of their staffs has also created a number of gaps, for during the war we tried to not overlap so that certain replacements were not made when vacancies occurred.

However, in spite of difficulties we are running a big institution and one that I feel is well worth while. Recently we have been helped out a bit by a number of UNRRA people. Dr. Leo Eloesser of San Francisco, chest surgeon, was here for a month. At present we have Dr. G. C. Schauffler of Portland, Oregon, obstetrician and gynaecologist, and a Norwegian dentist named Saxe. We are hoping for others later. Their help is most valuable.

I wonder if some Canadians could not be persuaded to come out for six months or a year. They would have to come at their own expense, I fear, for we do not have the money to find their support.

Yours sincerely,

"Leslie G. Kilborn, M.D."

Director,
College of Medicine and Dentistry,
West China Union University,
Chengtu, Szechwan.

* * *

Record in Twins

To the Editor:

Whether the following fact establishes a record I do not know but it seems unique for a small hospital (70 beds) serving chiefly a rural area.

From May 30th to August 4th, 1946, a period of approximately nine weeks, we had six twin births. Of these, one pair were boys and the other five pairs were girls.

Yours truly,

"Margaret Jamieson, Reg.N.",
Superintendent,
Prince County Hospital,
Summerside, P.E.I.

The Leprosy Hysteria

A British expert on leprosy, Dr. Robert G. Cochrane, after a lecture tour in the United States, finds that in that country they have exaggerated their fear of leprosy to a point of hysteria. Lots of leprosy is as harmless as a birthmark, and the chances of contagion are limited. Only three to five per cent of healthy adults are susceptible to leprosy, even when in bodily contact with victims. In Dr. Cochrane's opinion the leprosy "bugaboo" sprang mainly from an early, faulty translation of the Old Testament, in which the translator lumped a group of terrible diseases erroneously under the name leprosy. Deploring the publicity recently given to the case of an army major who wanted to join his wife stricken with leprosy in the leprosarium at Carville, La., Dr. Cochrane stated that after seeing her, in his opinion there was practically no danger that she would pass the disease to her husband and, as a matter of fact, she has an excellent chance of recovery.

—Hospital Topics and Buyer.

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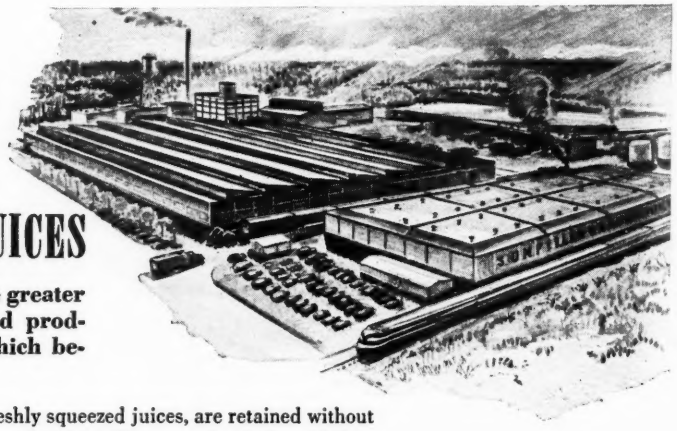

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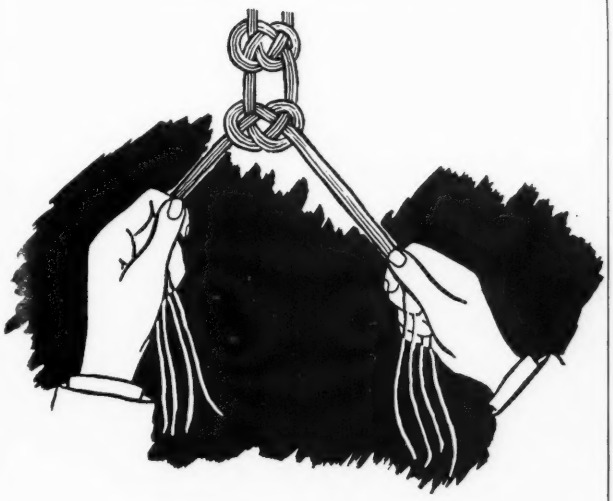

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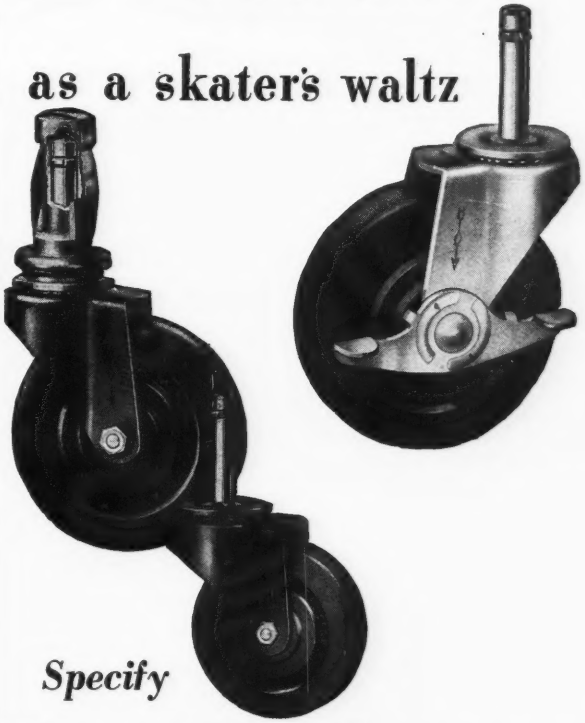

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Hydroponic Vegetables Found Valuable by Canadian Army

Geographical location and enemy activity may isolate soldiers from their supply of food, and under such situations nutritional disturbances are likely to arise. Apparently, vitamin pills do not provide all the factors necessary to maintain optimum nutrition and, if soldiers are isolated for long periods of time, it is well to supply them with adequate amounts of fresh vegetables. In northern Canada, especially Goose Bay, Labrador, isolated Army units were stationed to provide ground defence for air force and radar installations. Initially, because of low priority, air supply of vegetables was not possible and since the soil at Goose Bay is sandy, acid and barren, it was not possible to grow vegetables. It was decided to try to apply hydroponic growth methods in this northern outpost. Hydroponic agriculture consists of seeding vegetables or other plants in beds made up of sand or clinkers and supplying nutrient chemicals at regular intervals to support plant growth.

In the spring of 1943 two types of hydroponic beds were set up; a concrete type, of which only one was built, and in which the nutrient chemical solutions were pumped up from a tank into the sand bed twice a day. In a second wooden type, of which 86 were built, the chemicals were surface spread and watered by hand. To get over climate difficulties a hot house was built to force young plants during the prolonged northern spring. The sand beds were raised well above the ground to protect plants from ground frost; warm nutrient solutions were used and special care was taken to see that the plants were not damaged by icy rains, which occur in Labrador even in midsummer. Special hardy and quick-ripening northern varieties were planted, and by the middle of summer it was not uncommon to see soldiers, with their rifles slung over their shoulders, coming straight off sentry duty and wandering among the beds touching and fingering the growing plants.

The application of hydroponic growth to northern climate, where malnutrition has always prevented colonization, may be an important step in the agricultural development of the north.

In the absence of fresh vegetables, sprouted beans and peas can be used to prevent scurvy. This ancient Chinese therapeutic measure was used again in this war by the Russians during the siege of Leningrad and by the Australian forces during the Owen Stanley Campaign.

Investigations were made on over 100 varieties of sprouted beans and peas. Optimal methods were determined for producing vitamin C and other vitamins, by the germination of seeds, in military installations and in the field. Attractive recipes were also developed to make sprouted materials acceptable without destroying their nutrient value.

—Journal of the Canadian Medical Services.

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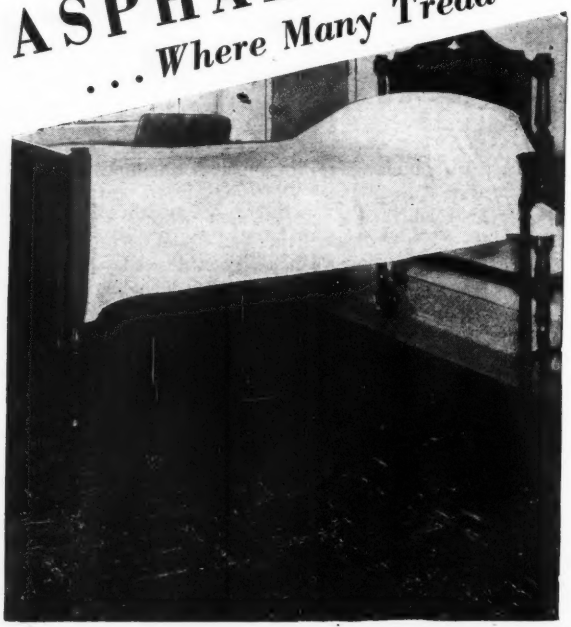

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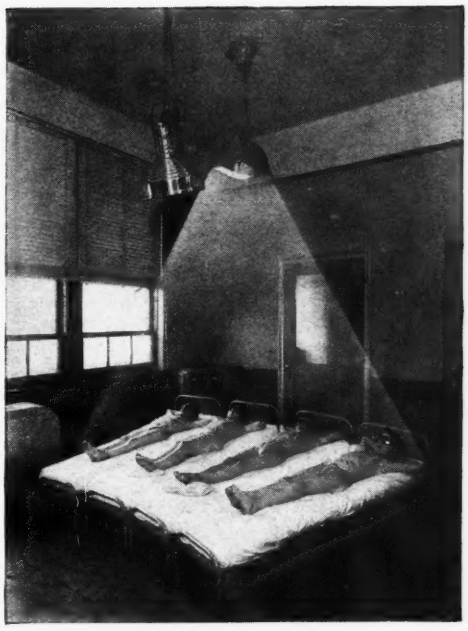

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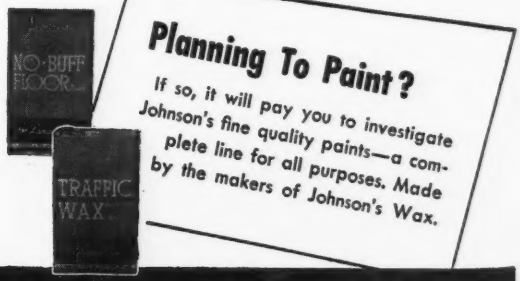

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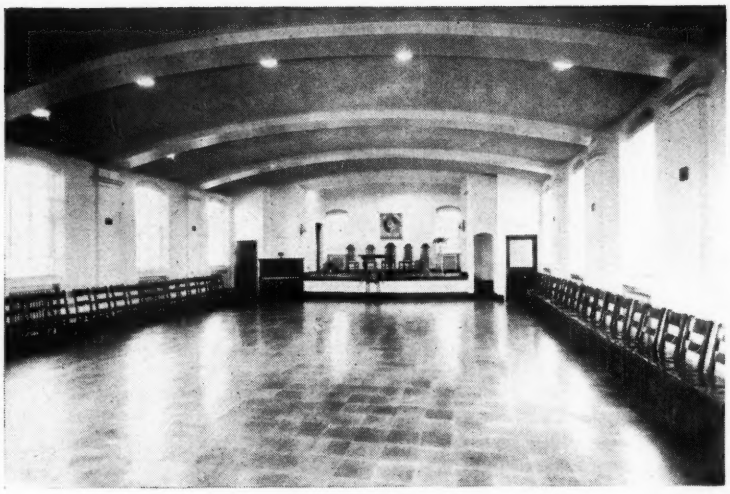
Chronic Patients

(Concluded from page 37)

tras". We find that only a small percentage of patients can pay even ward rates, let alone extras. All too often the chronically-ill have already spent their available funds during the acute stage of their illness. As for rising costs and rates, it is very difficult even to consider raising the daily rates to cover the rapidly-rising costs of today. It is difficult for a patient to meet hospital costs for a short period, but this becomes a burden of the first magnitude when the illness drags out over a long period.

The Queen Elizabeth Hospital is erecting a new 250-bed building which will attempt to provide physiotherapy and other treatment facilities excelling anything yet provided in hospitals for chronic diseases in this country. We do desire to make this service available to those who can benefit from it or need it, and not to waste it on those who need it not.

There is a tendency to look upon the hospital for chronic diseases as being essentially for the elderly patient. We admit patients as young as seventeen years of age. The hospital for chronic diseases is a hospital for adults needing skilled nursing and medical care for a longer period of time than is feasible in an active hospital; it should not be confused with "homes" for those suffering from physical incapacity only. Until homes for the latter are provided, the crowded conditions in all hospitals—active, convalescent, chronic—cannot be relieved.



The Auditorium

Nothing can be done without preconceived ideas; only there must be wisdom not to accept their deductions beyond what experiments confirm.—*Pasteur.*

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Research and Pharmacy

(Continued from page 47)

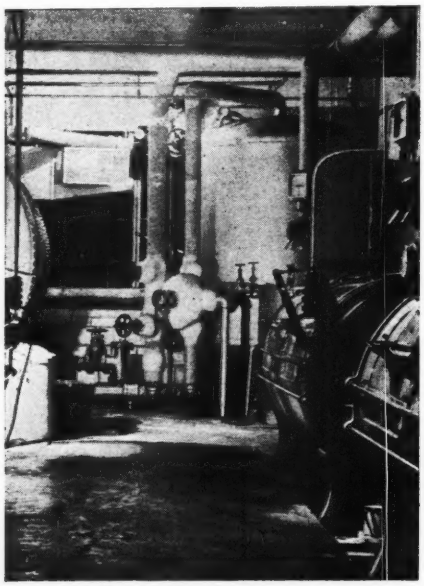
newer weapons have had to be devised against more heavily armoured battleships and tanks, just as faster and more destructive pursuit planes have had to be built for each successive generation of bombers, so we too may find ourselves committed to an unending search for ever new bacteriostatic and antibiotic weapons, natural or synthetic; neither sulfadiazine nor streptomycin is the end of the road.

The pharmaceutical industry has not, I think, looked forward to a day when disease shall be no more; and indeed this day may be extremely distant. I suggest to you, however, that as preventive medicine expands and learns its business, it may well need as much help from the pharmaceutical industry as curative medicine does . . . In another generation we shall have a preventive pharmacopoeia alongside our curative one.

The work of science is of two kinds. On the one hand it makes hundreds and thousands of observations and experiments and seeks to collect and classify these into laws; this is proceeding from a multitude of particulars to a few generalizations. On the other hand, it tries to proceed also from the general to the particular; to apply its established laws to some specific problem, and to tell us how best to attain some desired objective. These two processes are called the "fundamental" and the "applied" aspects of science. It is with the latter that your laboratories are chiefly, though not wholly, concerned.

Think of Becquerel's discovery of radioactivity, of Fleming's discovery of penicillin—both, like so many others, products of the reaction between an unpredictable accident and an alert mind. There is no reason why such discoveries should not be made in an industrial laboratory, except that there is always some pressure to produce results of practical applicability; and on the whole the universities provide a more favourable mental climate—a higher intellectual rainfall—for really new and unlooked-for discoveries. Without labouring that point, I wish also to suggest that whether the universities are a source of ideas or not, they are indisputably a source of trained men. The universities are therefore indispensable to your own research laboratories, possibly as purveyors of ideas, certainly as purveyors of technical personnel.

Many of the firms represented here have been generous to the universities, and have given out large sums, often with little enough in the way of tangible results, as research grants. I myself have reason to be grateful for assistance of this kind, so that it is hard for me to force myself to say what should be said: that it is not enough. It is to your interest that the universities should be well staffed: the quality of your own scientific personnel will depend on the quality of their teachers. Do your research grants do anything to maintain the quality of teaching within the universities? Yes, something; they make the life more interesting, they stimulate the teacher to keep himself alert by research, and this is important. But they do not help him to pay his rent or educate his children, and therefore they do little to keep him in the university where he



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St. Thomas's, London

(Concluded from page 35)

outpatients, of which there were 400,000 last year and 600,000 annually before the war, will have tearooms, a tobacco and sweet shop, a bookstall and possibly a cinema at their disposal. The outpatients' wait to see the specialists will as far as possible be abolished by fixing appointments, as is done by the private practitioner.

Nor have staff amenities been forgotten. Student accommodation and quarters for sisters and nurses will be in new buildings set among trees and flower beds with a green space in the interior of the group of buildings. Assembly hall, swimming pool and other recreational facilities are planned.

(Readers will recall that the chairman's mallet and block presented to the Council by Mr. C. E. A. Bedwell, our London correspondent, was made of wood and stone taken from the ruins of one of the buildings of St. Thomas's after an air raid. These were first used at the Hamilton meeting last year.)

Pasteur's Spirit Lives

(Concluded from page 49)

extend the limits of visibility of germs and to photograph elements that the optical microscope does not show.

Recent progress in chemical therapy is due to the close collaboration of chemists and bacteriologists; the sulfamides and penicillin are an outstanding example of this. In fact, it was at the chemical therapy laboratory of the Pasteur Institute that the properties of p-aminophenylsulfamide, basis of sulfamide therapeutics, were discovered. Clinical study of this drug was carried on in conjunction with bacteriological study at the Institute's own hospital, built some months before the death of the master for the application of his methods.

The brief description we have given of the Pasteur Institute would be incomplete, inexact even, if we did not praise the spirit that reigns in the House of Pasteur, the enormous amount of work that has been done there and the enthusiasm with which the work is carried out. Those who succeeded Pasteur's first followers have kept faith with them. The memory and example of Pasteur still inspire them, unite their efforts and give to the body of our research workers a soul and a unity.

Research and Pharmacy

(Concluded from page 106)

belongs; and they do not in general reach down to the fundamental disciplines of pure chemistry or physics or mathematics, on which the training of the biochemist or pharmacologist or bacteriologist depends. The gifts made by the pharmaceutical industry to the universities are generous, and are appreciated; but they contribute little to the gravest problems of maintaining universities, and they are offset by your industry's habit of tempting good men away into industrial laboratories and applied research. I suggest to you, in your own long-term interest, the desirability of endowing professorships in which first-class men could forget financial worries and devote their lives to untrammelled research and education.

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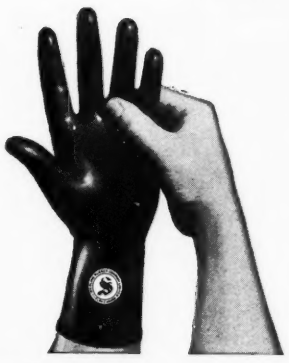

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Plan New Red Cross Outpost Hospitals

The development of outpost hospitals and nursing stations in new and remote communities across Canada was one of the most important activities of some of the provincial divisions of the Red Cross between the first Great World War and the one just concluded. Although at the beginning of this war a great many communities in Canada needed this type of service, there has been practically no augmentation of it—indeed, if anything, there was a slight shrinkage during the past six and a half years. At the end of 1945 there were forty-three of these hospitals in operation across the country. During the year 33,200 patients were given treatment, 2,107 babies were born and 5,176 operations performed. There were 576 children's clinics conducted and 14,185 children were examined. It is interesting to note also that 393 schools were visited by the Red Cross nursing staff—these schools all being in remote and very isolated districts in Canada.

Now that the war is over, all the Divisions of the Red Cross are vitally interested in this Outpost Service. In accordance with the plans which already have been made, there are likely to be somewhere in the neighbourhood of twenty-five new outpost hospitals or nursing stations added to the number already in operation during 1946.

—From the 1946 Report of National Commissioner F. W. Routley, M.D.

Drug Shortage Looms As Result of Meat Racket

The black market in meat threatens to create a shortage in insulin and other pharmaceutical products made from animal glands, a Houston, Texas, packer has recently informed the Senate Agricultural Committee. He said that black market slaughterers, unequipped to process or preserve such parts, were throwing them away.

Various pharmaceutical laboratories have reported production curtailments ranging from 50 to 90 per cent of medicines made from meat by-products. In addition to a serious shortage of pancreas of all sorts for the production of insulin, diminished supplies of pituitary and suprarenal glands, ox-bile, and calves' livers are said to present a grave threat. The shortage, which has not yet been felt by wholesale and retail druggists, may affect physicians in another month, manufacturers say.

—Medical Economics.

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New University Courses in Hospital Administration

Announcement has been made that courses in hospital administration will be established this fall at Washington University, St. Louis, and the University of Minnesota. The Kellogg Foundation has awarded grants to each institution for this purpose. The grants will continue annually for a three-year period.

At Washington University the course under the directorship of Dr. Frank R. Bradley will limit enrolment during the first year to ten students. The course will be at graduate level and open to persons holding a degree from a recognized college or university. Mr. Graham Stephens, graduate of the Chicago course and formerly assistant director of Evanston hospital, now on the staff at Barnes Hospital, will assist in the conduct of the new course.

The course at the University of Minnesota will be offered through the School of Public Health. It will be open to twenty students holding at least a bachcelor's degree. Two years of study and an administrative internship will be required to qualify for the master's degree. The course is being planned by Richard Koselka, Dean, School of Business Administration; Ray M. Amberg, Superintendent, University Hospital and Dr. Gaylord Anderson, Director, School of Public Health.

Statistics on Hospitals

(Concluded from page 56)

The Indian Health Service of the Department of Health and Welfare operated 13 hospitals in Canada for the care of Indians. Two of these hospitals were for the treatment of tuberculosis only, while all but two of the remaining eleven reported a part of the hospital set aside for tuberculosis patients.

The thirteen hospitals reporting had a bed capacity of 533 beds and cribs and 41 bassinets.

A list of other hospitals operated by the Department of National Health and Welfare, the Department of Veterans Affairs and the Department of National Defence (Army) in 1944, is also included in this volume.

U. of Sask. Medical School Advisory Council Named

Appointment of a four-man advisory council for the college of medicine at the University of Saskatchewan, under the provisions of the University Act passed at the 1946 session of the legislature, has been announced by Premier T. C. Douglas, minister of health. The members of the council are Dr. W. S. Lindsay, dean of the College of Medicine, University of Saskatchewan; Dr. J. F. C. Anderson, Saskatoon; Dr. C. F. W. Hames, deputy minister of public health; and Dr. F. D. Mott, Chairman of the Health Services Planning Commission.

According to the terms of the Act, Dr. Anderson was appointed by and represents the College of Physicians and Surgeons. Dr. Hames and Dr. Mott were appointed by the minister of public health. Dr. Lindsay, as dean of the College of Medicine, is a member *ex officio*.

The duties of the council are to report to the senate and the board of governors of the university concerning entrance qualifications, courses, general regulations and related matters.

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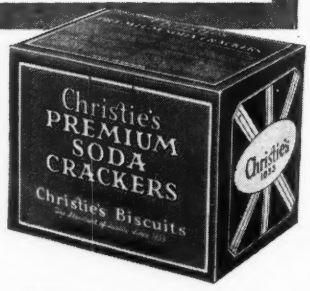

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